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Between Ourselves

Announcement has been made that the seventh annual observance of **Health Week** is scheduled for ***February 4-10, 1951.*** The first Wednesday in February is National Social Hygiene Day in Canada and the United States. Bearing in mind that the primary purpose of designating a special period as Health Week is to make all Canadians more health conscious what are some of the things that nurses can do to assist? The following suggestions may be worked out to advantage in various communities:

1. *Newspapers:* Special Health League releases are available or prepare your own news of local health activities.
2. *Radio:* Spot announcements; talks by local health authorities; planned interviews with people prominent in the health and medical fields.
3. *Men's and Women's Clubs:* Provide speakers on health topics; suggest the use of special health-food menus at luncheon meetings.
4. *Retail Merchants:* Attractive window displays using general health themes or featuring some one phase of the broad program; arranging for special health talks during employee meetings.
5. *Industrial Firms:* Appropriate posters on employee bulletin boards; special employee members addressed by plant physician or nurse; health items in the plant publication.
6. *Schools:* Health essays and poster contests; showing of special health films; special talks, especially to the senior students.

Send us an account of any special projects you may work out for inclusion in a later issue of the *Journal.*

* * *

If you read Lyle Creelman's letter in the November issue you will recall that she referred you to the splendid paper presented by **Sir James Spence** during the conference on pediatrics held in Zurich last July. The caption has been altered but the information he presented is all there for you to read, absorb, and apply. We think you may be startled by some of the new and different patterns of patient care he describes. Some parts of it you will more than likely want to have your pediatricians read too.

Incidentally do you make a point of showing your copies of our *Journal* to the doctors with whom you work? So frequently we hear of some misinformation regarding nursing developments that can be traced to a medical man's opinion. In all fairness to him we should supply the facts about what nursing is doing to meet present-day problems in patient care. Who knows? You might even interest him in becoming a subscriber!

* * *

One of the most progressive mental health programs on this continent is fully described for you in **Eleanor M. Heady's** excellent article. If emotional upsets, anti-social behavior, and personality maladjustments were communicable diseases we would all be in an uproar over the pandemic proportions these conditions had reached. Perhaps if we realized the extent to which we all as adults are responsible for the untoward attitudes that develop in children we would understand that, though no bacteria or virus can be traced as causative agents, there is a definite process of transmission that produces these unhappy states of mind. Mrs. Heady tells us how, through mental health clinics, an endeavor is being made to provide the necessary remedies.

Isabelle Godek attacks the same problem from a different angle. She has worked out a detailed outline that shows step by step how, in learning to care for infants and children in the course of their pediatrics training, nurses have an opportunity to acquire the skills in handling children so that behavior problems may occur less frequently. Sharing this information with parents is an important part of the nurse's responsibility. Children learn best by example. Most negative, carping criticisms of conduct can be expressed in a positive complimentary way. If everyone, children and grown-ups, could realize that it is important to add as much happiness as possible to the lives of those around us, we would all enjoy one another much more.

What people say behind your back is your standing in the community in which you live.
—E. W. Howe

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Edited by **PROFESSOR F. N. HUGHES**

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Manufacturer—E. R. Squibb & Sons of Canada Ltd., Montreal.

Description—A new potent analgesic combination containing the new compound, acetyl-p-aminophenol, which appears to be relatively free from side effects. Each scored tablet contains: Acetyl-p-aminophenol 0.125 gm. (2 gr.), caffeine 0.030 gm. (½gr.), acetylsalicylic acid 0.230 gm. (3½ gr.).

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Manufacturer—G. D. Searle & Co., Chicago, Ill. Canadian agents: Laurentian Laboratories Ltd., Montreal.

Description—Each scored tablet contains 50 mg. of banthine (Methantheline, Searle) bromide.

Indications—For control of vagotonia and parasympathotonia of peptic ulcer.

Administration—Initially, usually 50 to 100 mg. every 6 hours; dosage adjusted subsequently to patient's needs and tolerance. Usual adjunctive measures of diet, rest, etc., should be prescribed for a few weeks at least.

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Manufacturer—Sherman Laboratories, Windsor, Ont.

Description—Saline solution of crystalline vitamin B_{12} containing 30 micrograms/cc., the anti-pernicious anemia factor of liver in pure crystalline form.

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Administration—Intramuscularly, in doses according to the need and response of the patient.

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Indications—Acute and chronic rheumatic fever; arthritis.

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Manufacturer—Ayerst, McKenna & Harrison Ltd., Montreal.

Description—Each capsule contains: Vitamin B_{12}, 10 mcg.; desiccated stomach tissue, 250 mg.; folic acid, 0.67 mg.; ferrous sulphate B.P., 320 mg.; ascorbic acid, 50 mg.; liver extract equivalent to 1 gm.; (to provide natural vitamin B factors).

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Administration—Orally. In most conditions, one capsule 3 times daily after meals. In pernicious anemia, it may be necessary to increase this dosage in the initial stages, in relapse, or where there is combined degeneration.

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Manufacturer—Davis & Lawrence Co., Montreal.

Description—Each coated tablet contains: Thiamine HCl 1.33 mg., riboflavin 1.33 mg., niacinamide 6.67 mg., sodium glycerophosphate 2½ gr., calcium glycerophosphate 1½ gr., iron glycerophosphate 1 gr., strychnine glycerophosphate 1/75 gr., malt diastase 1 gr.

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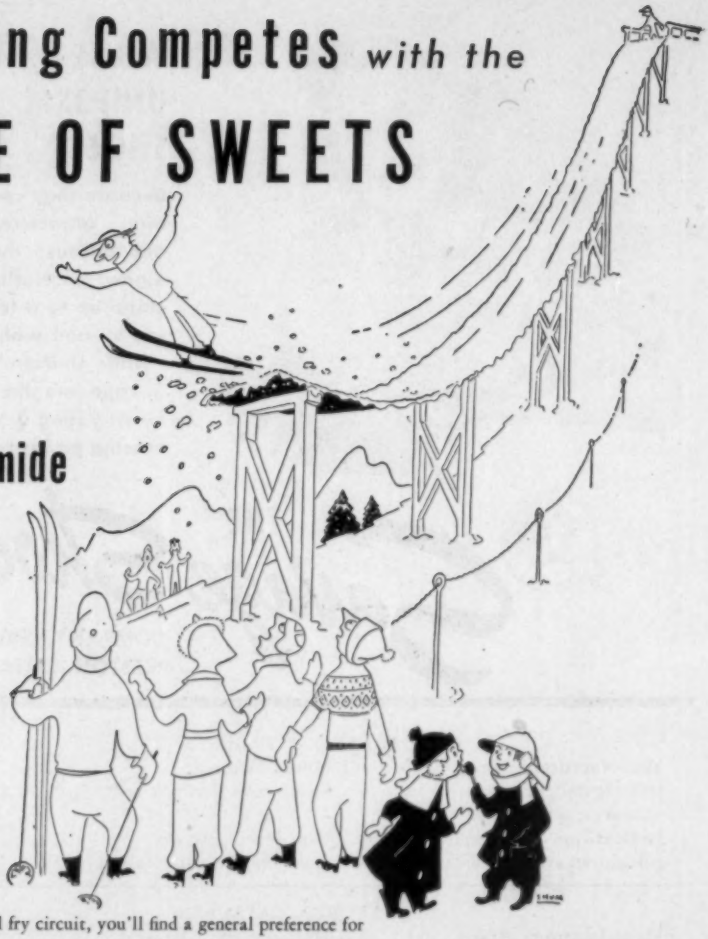

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The
CANADIAN NURSE

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PUBLISHED BY THE CANADIAN NURSES' ASSOCIATION

VOLUME FORTY-SEVEN *NUMBER ONE*

MONTREAL, JANUARY, 1951

A Satisfying Life

Average reading time — 7 min. 12 sec.

But, spite of all the criticising elves,
Those who would make us feel—must
feel themselves.

—CHARLES CHURCHILL

LOOKING TO the New Year, nurses might well wish the silencing of the "criticising elves." Nurses have become a topic of discussion in so many areas since the general realization that nurses and more nurses are needed if plans for the protection of the health of our nation and the world at large are to materialize. The possibility of failure due to any one group is uncomfortably considered as the people demand social services to meet their needs and as an attempt is made to meet these demands by expedient plans. The flaying of someone nearby when plans are slow is not a new pastime for human beings. And so, a scant supply of nurses bear the brunt of professional and lay criticism as the wheels turn slowly and with difficulty towards the implementation of the health aspects of social security.

Comments in the press and radio, from the platform or in general conversation, frequently turn to the theme that nurses have changed since "the good old days." Each group or individual brings forth some piece of evidence to prove it. Nurses want higher salaries, shorter hours, longer holidays, sick leave benefits, and pension plans for their old age. They want maids to do the scrubbing and washing, auxiliary workers to carry nourishments and do the flowers, and the doctors to accept them as one of the team instead of the faithful handmaiden. Nurses now ask for financial support for their schools so they no longer need be apprentices while learning the art and skills of nursing. They want adequate facilities in the hospitals, clinics, and homes in which they practise. To some, it seems as if there is no end to the wants and by some they are interpreted as demands—selfish demands.

It is generally accepted that nurses act with courage when sacrifice is inevitable as in pioneering or in time of war. "Beyond the call of duty" is a phrase often used when speaking of nurses in time of disasters. It is when nurses seek the right to nurse, with the skills that are particularly their own, under conditions that make it possible for them to demonstrate the

full meaning of the word "nurse," that the voices are raised.

What is the answer? Perhaps Dr. Reider[4] expressed it when he recently suggested that a good slogan for nurses would be "a little less sacrifice and a little more personal satisfaction." He went on to say that it is not merely an assumption that a happy nurse is a good one, that one who is able to attain satisfaction in her work and in her outside life is a more effective nurse, and that the dissatisfied nurse takes it out either on her patients or herself.

The provision of a professional environment in which all nurses may be happy is, of course, not entirely within the hands of the nurses themselves. But administrators can see that the autocratic system in nursing education and nursing administration is replaced by democratic relationships. It is essential for each group of nurses to support and strengthen those within the group who need it most. Each nurse can strive to cooperate with her fellow workers, giving recognition to her superiors or her subordinates for work well done. Who will dare say our motivation is selfish if by considering the human needs of ourselves we develop an ever-increasing understanding of basic human needs and, in undertaking them, give greater service to our fellowmen. Others have supported us in this regard:

> It is an elementary principle that failure to reward effort and achievement will lead to serious frustrations and, furthermore, if the situations persist, will deter the exercising of initiative in the future.—GINZBERG report[2]
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> * * *
>
> Only when abiding conviction of social worth replaces lack of self-confidence, negativism, and carping comment will that climate of opinion be created whereby nursing can move forward to greater selectivity of personnel and to a level of nursing care that bespeak growth and development for the nurse herself and more and better health service for society.—ESTHER LUCILE BROWN[1]
>
> * * *
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> Any individual, including any nurse who becomes routinized and rigid, established and complacent, is falling short of her maximum self-realization or her greatest satisfactions. Such a state of affairs only means resignation. Nurses do not have to give up being women and citizens. It is unfortunate if they should give up their dreams and hopes for a home and family. Certainly, inside and outside of hospitals, nurses are also citizens and live in communities. Never need any nurse permit herself to become an isolated, one-track spinster, and it is extremely unfortunate if the nursing profession, either because of its present make-up or because of its attitudes, ever permitted such a prospect to be accepted as the expected outlook of the nurse.—DR. WILLIAM C. MENNINGER[3]

Need nurses lack convictions when others such as these speak out for them? We must seek the help of others in relation to the factors over which we have no control and strive to correct the social ills which plague us from within our own ranks. Confident of our motives we can turn our backs on the "criticising elves" and seek "a little less sacrifice and a little more personal satisfaction."

May the coming year bring to nurses great opportunities for service and great happiness in giving it!

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HELEN G. MCARTHUR
President
Canadian Nurses' Association

Humility leads to strength and not to weakness. It is the highest form of self-respect to admit mistakes and to make amends for them.—JOHN J. MCCLOY

Greetings from an Oldster

HELEN RANDAL

Average reading time — 4 min. 6 sec.

I HAVE BEEN ASKED to bring greetings to the nurses of Canada as 1951 begins to unfold. It is perhaps appropriate that at the beginning of the latter half of this century I, who, in April, 1950, celebrated the Golden Jubilee of my association with the nursing profession, should extend my very best wishes to you and the Canadian Nurses' Association for the new year that is upon us.

Looking backward, one sees such wonderful changes that have taken place during this span of years—changes in nursing techniques, in conditions of nursing life, housing, hours—as well as improvements in the nation-wide standards of professional education. These will, we hope, among further changes and improvements, bring provincial standards to the point where our aim over so many years—Dominion Registration—may be possible.

To me, nursing has been a most interesting and vital life. I do not believe there is another profession or career for a woman which brings such variety, such close personal contact with those we serve. No matter which of the many fields attracts the nurse, she can never lose this sense of service to a single patient or to the community. Improved working conditions and shorter hours have helped to give the nurse sufficient time for recreation and to broaden her life. This is all to the good if, at the same time, it is not forgotten that *service* comes before all else. Life and death so often demand more than the regulation hours of duty. If one is a true nurse these emergency calls will be answered.

With improved conditions in schools of nursing and the larger, more numerous fields where the nurse's personal preference for professional work can be satisfied, there is every reason why we can look forward to as high a level of professional achievement in Canada as anywhere in the world. This success would bring joy to those of us who pioneered in nursing many years ago.

I would like to say a few words to, and about, those "pioneers in nursing." To those of you who are still with us—whether active or retired—a very special New Year's Greeting. It is many a long year since we met together in "The Society of Superintendents of Training Schools of Canada." It is fitting that the nurses of today should be reminded of those who made wholehearted efforts to raise nursing standards in spite of so many difficulties. As practically every hospital was a so-called "training school for nurses," the membership took in virtually every one of the women whose special work was the

HELEN RANDAL

Miss Randal is also well known to thousands of Canadian nurses for her sterling qualities of leadership. She was first registrar and executive secretary of the Registered Nurses' Association of British Columbia, serving thus from 1918 until her retirement in 1941.

instruction of students—the basis of all nursing. Their efforts were of tremendous value in the earlier days of nursing.

I am very proud of my association with this valiant group. It was my privilege to serve as president of the society from 1914 to 1918. Our conventions were held annually in conjunction with the Canadian National Association of Trained Nurses. As all the members of the Superintendents' Society were also members of the C.N.A.T.N., discussions regarding the advisability of amalgamating the two bodies were started during my years in the chair. The actual fusion did not take place until 1924. The last convention of the society, by then called the Canadian Association of Nursing Education, was held in 1922. It joined with the C.N.A. as the Nursing Education Section and is still active today as the Committee on Institutional Nursing. Not many nurses seem to know much about the history of either organization. I hope it will be written in detail some day.

It is pleasant to be once more between the covers of *The Canadian Nurse*. I took over the work of editor and business manager in 1916 when the C.N.A. bought the publication rights from the advertising firm that had issued it among "trade journals." My association with the *Journal* lasted for eight years and, through it, many nurses from all parts of Canada, including Newfoundland, became well known to me.

So, to all nurses, not only those whose names are familiar, but to the numerous women who have persevered in striving for the better preparation of student nurses and who have accepted the task of improving the working conditions of nurses; to all engaged in private nursing—who are not so numerous as in the days when I was in active work; to all public health nurses serving in the larger fields—I bring my New Year's Greeting. My hearty wish for you is that every day may be so full of opportunities to serve that at the end of your nursing career, whether early or late in life, when you look back on it you will be able to say as I do today: "It was a happy and satisfactory experience." May 1951 bring you great riches of happiness! May it be filled with the joy of service!

Living Costs

One of the most frequent topics of conversation, of newspaper notations and magazine articles is the soaring level of prices for every type of commodity. Though nurses' salaries are at a higher level than at any time in our history, most of us find that it is just as hard to make the money go around as it ever was.

Recently, an old ledger reached our desk. In the front is inscribed, "My first book of house accounts commenced three days after I was married—September, 1879." As well as being amazed at the enormous differences in prices, we were amused by some of the items listed under housekeeping expenses—"Harry's tooth filled, $1.50"; "Harry's hair cut, 15 cents"; "Butcher cheated, .01 cent"; "Church, 15 cents."

With rent at $8.00 and the maid's wages of $5.00 to pay each month, she managed to keep house on between five and ten dollars a month! Typical entries are as follows:

Tub	$ .90
Bread tickets (20)	1.00
Bushel of potatoes	.90
Beefsteak	.10
3 lb. roast beef	.48
Milk, at 2 cts. a pint	.60
Butter for the winter, 60¼ lb.	10.68
Coal oil, 2 gal.	.30
Turkey	.65
Dozen eggs	.07
Sugar, cream, cheese, and steak	.62
Tablecloth	1.50

In March there is a notation: "Commenced making our own bread." She had quite a problem balancing her accounts each month. Usually she was out a few cents in her reckoning—"Balance I should have $2.50. Balance I have $2.28." After the orgy of Christmas entertaining where there is even an entry of "Brandy, $1.00," the grocery account of $8.53 balanced. The page is closed with the cheering statement, "Right to a knockdown!"

The Doctor, the Nurse, and the Sick Child

SIR JAMES SPENCE

Average reading time — 11 min. 36 sec.

THREE RULES govern the collaboration of doctors and nurses in the care of sick children. They relate to (1) defined responsibility, (2) separate responsibilities in an equal partnership, and (3) the ultimate responsibility which lies with the sick child's parents and which is based on a concept of our Western civilization.

The first rule applies to all human affairs, for without a definition and acceptance of responsibility there can be no morality or efficiency in social life. But it has a particular relevance in medicine and nursing because they are engaged in the intimate occasions of life and death. It has a still more particular relevance in pediatrics.

In a big pediatric service there is a danger that the rule may be lost sight of or forgotten. When I speak of recognition and acceptance of personal responsibility by doctors and nurses, I mean that the parents of a child in a hospital and the director of the hospital should know or be able to find out which doctor undertakes each particular responsibility for the care and treatment of each child.

The responsibility is personal in the sense that it should be traced to one doctor. It may lie with the "chief of the clinic" but it is, nevertheless, a personal responsibility. In England we have an old proverb that "what is everybody's business is nobody's business" and another that "too many cooks spoil the broth." So it is with medicine. A patient is much safer under the responsibility of one doctor than he is under the responsibility of many doctors, even though they be skilled spcialists. Indeed there may be a possible danger to a patient to be treated by too many specialists at the same time.

We are concerned, however, with the adjustment of the doctor's responsibility to the nurse's responsibility. Historically the responsibility of the nurses precedes that of the doctor. Originally a hospital was a place of nurses. It is only in the course of the last 50 years that doctors have had such dominance in hospitals. It is the nurse's duty to arrange the supervision of the sick in hospital, to watch the hour to hour changes in their illnesses, to provide for the comfort of their bodies and minds, to provide their encouragement, and to eliminate their fears. She then interprets the patient's condition and needs to the doctor. Traditionally this was arranged by giving ward sisters or head nurses the authority in all matters concerning the hour to hour care and comfort of patients and placing her sleeping room in or near her wards. This was the centre of social and professional life.

In modern hospital buildings we have discarded this idea of devoted monastic and we are not likely to return to it. Nevertheless I advocate the retention of the head nurse's authority on all matters concerning the immediate care and observation of her patients. Her position could be symbolized if each ward had an entrance door at which the visiting doctor knocked to seek admission, by asking if it were convenient for him to visit the ward and examine or treat the patients. Such symbols would help us to see more clearly the responsibilities of the nurses. Too often, nurses are acting as subordinates of their doctors.

In a pediatric service the head

Dr. Spence is professor of pediatrics at Durham University, England. This paper was delivered at a special conference of the Sixth International Congress of Pediatrics held in Switzerland last summer. It is being published simultaneously in our *Journal* and in the *American Journal of Nursing* with the kind permission of the author.

nurse and the staff nurses act as substitute mother for a number of children. As a mother is much engaged in the relationships of her children, so a nurse in a pediatric ward should give much thought in the grouping and regrouping of beds to provide harmonious companionship between the children. Too often a child is confined to a bed for technical convenience, however incompatible his neighbor may be. A good nurse recognizes this need to change the child's location to give companionship.

While the location, the treatment, and the comforting of children in the hospital are the prime responsibility of the nurse, the doctors can collaborate in this with her. This can be achieved if the senior doctor does a ward round with the nurses once or twice a week, when discussion is devoted not to the clinical features of disease but to the arrangement of the beds, the parents' visits, and the children's occupations. A regular ward round and discussion of this sort would prevent nurses from becoming merely therapeutic technicians which is a danger in children's hospitals where so much intricate treatment is required.

A nurse can play an important role in clinical observation and in this she collaborates with and assists the doctors. For this purpose nursing education should include exercises in observing an acutely ill child and noting these observations in a written record. This must be much more than the ritual of taking pulse and temperature. Indeed, much counting of pulse and taking of temperature could be dispensed with and replaced by this new kind of observation. It should include observations in the variations in sleep, the character of cry, the state of consciousness, the degree of anxiety, thirst, and pain. Children who are severely ill from trauma, or burns, or poisoning are good subjects for these exercises. I suggest these exercises because I find that mothers are often more accurate observers of the change in a child's illness than a young doctor or nurse. If nurses are encouraged and trained in this kind of clinical observation and recording, we improve collaboration.

Collaboration between the doctor and the nurse in children's hospitals where mothers are admitted to nurse their own sick children and in the pediatric service of maternity hospitals requires special consideration. In these hospitals it is easy to see that pediatrics is concerned with something more than nursing and the treatment of children. It includes encouraging the mother to develop her own skills by which she remains the chief instrument of child care. If pediatrics neglects the mother and diminishes her confidence and skill it will do more harm than good.

Doctors and nurses in a maternity hospital should ensure not only that a woman is delivered safely of her child but do it also in a manner which leaves the woman free from the fears of having another child. For this they should allow the mother to participate quickly in the care of her child. The best arrangement is in single rooms or small wards where the child remains in its crib at the bedside of the mother and within easy reach. She can then pick up or comfort her baby when she desires and everything that is done for it is done under her eyes.

I have worked for many years in maternity hospitals having these arrangements. In America recently they have called it "rooming in" but where "rooming in" consists of placing the crib beyond the reach of the mother—at the foot of the bed or in another corner of the room—it defeats its purpose and is unsatisfactory. Collaboration in a maternity hospital becomes a triple relationship of the mother, the nurse, and the doctor and the technique of doctor's ward visits should be adjusted to this relationship. When he comes to the bedside he first asks the mother, not the interne or the nurse, about the baby's condition. She gives her report. Technical discussions between doctor and nurse take place later beyond earshot of the mother. That simple device encourages the right collaboration.

For many years also I have had experience in a hospital where the

mother is in the same room with her own sick child, to nurse and attend it. She carries out all the simple routine duties of nursing under the supervision of an experienced graduate nurse. This method is well suited to most patients under the age of four or five years who are in for a short stay. It is particularly suited to the surgical patients who must be in the hospital for about a week. I justify the method because it is good for the child. It is good also for the mothers who thereby gather confidence and experience. It is good for the doctors and nurses to perform their duties in the mothers' presence and so to foster the courtesy and care on which the practice of medicine depends. It is a cheap, humane, happy, and satisfactory method of nursing sick children. It requires that the nursing shall be done in single rooms containing both the mother's bed and the child's crib. My experience has taught me that these "mother-nursing rooms" are best grouped in a single unit designed for the purpose and not scattered as single rooms on a general ward. Under this arrangement we have designed for the triple relationship of responsibility between mother, nurse, and doctor that I have described in maternity hospitals.

I have spoken of the definition of responsibility without which collaboration between doctor and nurse may fail. An example of this failure is often seen in the reports given to parents about their children in the hospital and the advice given to parents when they take their child from the hospital. Keeping in mind the need to enhance a mother's confidence and skill there is much value in these reports and the advice. Is it the nurse's or the doctor's responsibility to give these reports and directions? It is, I think, a responsibility of both the doctor and the nurse, each in his or her own way. It is also an opportunity to provide education for parents about the health of their children and the prevention of their illnesses. It also has educational value for doctors and nurses.

I can now gather the suggestions I have made about the value of collaboration between nurse and doctor and place them in sequence. The first is in the *field of education:* in the nurse's education where the doctor gives the nurse opportunities to exercise and cultivate her skill in clinical observations; in medical education where doctors may develop an interest in the techniques of nursing. This collaboration is best arranged in the practical work of the wards and not in classroom work in preliminary schools of nursing or lecture theatres. It can be achieved if the senior doctor takes the nurses on a ward visit to discuss each patient and if the senior nurse takes the young doctor on a ward round to discuss nursing techniques and difficulties.

A second field of collaboration is in *promotion of maternal skill and confidence* by which mothers become the chief instruments of child care. For this purpose doctors and nurses should restrain, in themselves and in each other, a tendency to professional domination of the mother. The soul of a nation is preserved in its mothers. A nation may achieve physical fitness through technical pediatrics but can lose its soul if at the same time it subordinates the responsibility of its mothers or diminishes their maternal skills. A civilization will lose its culture unless it upholds motherhood. This view can be substantiated on biological grounds alone, apart from all political and religious considerations, and is a matter demanding the collaboration of doctors and nurses.

The third field of collaboration is in the *technical treatment of patients within the hospital.* This can be precisely defined and requires little discussion. It is the responsibility of the doctor to prescribe and demonstrate and of the nurse to administer the treatment. So much modern therapy, such as injections of penicillin or streptomycin, terrifies a sick child that the nurse undertakes an important responsibility in suggesting to the doctor ways and means of diminishing the pain and fear of sick children. If the collaboration is an equal partnership the nurse should be

free to advise or criticize the doctor when he prescribes too many procedures. Nursing care of a sick child may degenerate when a doctor orders too much pulse counting, temperature taking, test-meal weighing, and record keeping. The nurse then becomes a mechanic and has no time for observing and comforting the sick child, which is her prime responsibility.

So far I have dealt with the care of children in hospitals, in wards, and out-patient clinics. Services outside the hospital are largely concerned with preventive pediatrics. In England these preventive services are built on two institutions: (1) the child welfare centres where mothers receive advice about the feeding, development, and minor ailments of children; and (2) the health visitor or public health nurse who combines work in the welfare centre with visits to the homes, especially for advice about the newly born, the control of tuberculosis, and the supervision of children with infectious diseases.

The child welfare centre depends for its success mainly on its nurse but a doctor attends each session to advise on children whom the nurse wishes him to see. Over the last 40 years the welfare centres have made an important contribution to child health in England. Located near the homes of the people, they serve as social and medical institutions and carry the goodwill and confidence both of the people and the medical profession. Their main function is health education. They are the more valuable because nurses and doctors share in the work.

The health visitor or public health nurse, who visits the homes of her families, is working in a more isolated field with less opportunity of direct collaboration with the doctor. Unless the nurse is tactful, jealousies and difficulties may be aroused in the medical practitioner and family doctors who work in the same district. It is worth recording, however, that in England very little discord or jealousy does arise. The nurses and doctors recognize each other's responsibilities and collaboration is generally close and harmonious.

In a final analysis collaboration between doctors and nurses becomes harmonious and effective if they have occasions to meet, to discuss their joint responsibility, and to recognize each other's duties. On the other hand, if nurses, doctors, and other social workers are too concerned with their professional status, too segregated by their specialist diplomas, and fail to meet for discussion, collaboration becomes difficult.

In summary, my final comment is that collaboration between the doctor and the nurse depends on mutual recognition of each other's responsibilities in an equal partnership; that it is endangered if either of them is too concerned with his or her own professional prestige; that to overcome this danger institutions should create occasions for reciprocal discussions of each other's duties; and that, in pediatrics, collaboration is made easier if both doctor and nurse realize that they must do their work in such a way as to raise the status of motherhood and the skills of mothers.

Contact Dermatitis

Several hospitals have reported that nurses and doctors who must handle streptomycin or penicillin sometimes become allergic to these drugs and develop lesions, usually about the fingers. . . . Much the same is likely to happen in a pharmaceutical house. Those who handle penicillin, streptomycin, and codeine have a higher incidence of contact allergy than is the case with other drugs. It was found that the prompt application of Cream 'Histadyl' (Lilly) relieved the dermatitis. However, as a rule it is necessary to transfer the worker to another job. The problem of how to predict who will and who will not develop allergy to a given drug is not easily solved. The majority of persons do not become allergic.

—*Physician's Bulletin*

Pre- and Post-Operative Nursing Care

VERNA WILLIAMS

Average reading time — 11 min. 12 sec.

THE PRACTICE OF SURGERY as we know it today owes its existence to scientific discoveries of the past century. Pain during surgery has been controlled by the use of anesthetics, hemorrhage by use of ligatures, infection by antisepsis and asepsis. It is true that every surgical procedure is still hazardous, though today in most instances that hazard is slight. Constant effort, however, is still being made and we find new facts, new principles, and new methods every day.

MAINTAINING MORALE

The general preparation for surgery includes, first of all, emphasis on the attitude and mental preparation of the patient since we know that anxiety may be a factor in post-operative shock and an important factor in convalescence of the patient. Every patient finds himself in a new environment, separated from everyone and everything to which he has been accustomed. Therefore, the patient needs reassurance; his comfort and the maintenance of his morale depends chiefly on the nurse. The confidence of the patient is gained by a sincere interest in his family, his occupation, his personal problems, aiding him to adjust to hospital routine, and reassurance regarding his progress. Reassurance is doubly important to those who may find it necessary to change their way of living as a result of their illness or injury.

Secondly, careful study of every aspect of each patient is necessary in order to minimize the risk and correct possible deficiencies. For instance, dehydration and dietary deficiencies may be corrected or an acute respiratory infection may warrant postponement in all but emergency procedures. Systemic disorders, as diabetes mellitus, heart disease, and nephritis are discovered and proper measures taken.

Miss Williams is a clinical instructor at St. Boniface School of Nursing, Man.

PREOPERATIVE CARE

Study of the patient's blood is made with particular reference to possible anemia or alteration of coagulation time. It is obvious that the discovery of any abnormality, other than that for which the operation has been proposed, calls for reconsideration of the whole situation and may necessitate a change in the plan for the patient. Since the nurse is the person in closest contact with the patient, one of her most important duties is the keen observation, prompt reporting, and accurate recording of patient's signs and symptoms. Failure to report a cough or slight temperature may mean a severe case of post-operative pneumonia. It should be the aim of every nurse to send her patient to the operating room in the best condition possible

If blood studies reveal low hemoglobin, transfusions and iron in various forms may be given. If blood clotting is retarded, a coagulant is given in some form of vitamin K. Vitamin K is also given as a prophylaxis in many cases where bleeding may complicate surgery, as in leg amputations, hysterectomies, or removal of a gall bladder. Ascorbic acid is often given preoperatively as an aid in repairing tissues. It is given by mouth or intravenous injection. Synthetic preparations of other vitamins, such as B, may be given intramuscularly or intravenously. Amino acids are also given as an aid in re-establishing protein balance. Every major surgical case is matched for transfusion and blood is prepared so that it may be given at a moment's notice.

It is important to remove nail polish from finger-nails so that the operating room staff may check on color.

It is the doctor's responsibility to order what he finds necessary for his patient but it is the nurse's responsibility to administer most treatments. Therefore, she must know the purpose of the medication or treatment and the reaction expected. It is also her duty to explain the treatment as simply as possible to the patient and thus gain his cooperation.

Saline enemas are given the evening before operation to the majority of patients, especially if the operative area includes the gastrointestinal tract. However, some doctors feel that if the patient has had a normal bowel movement the day previous to operation, it is sufficient and preferable. There is always a loss of fluid with an enema and maintaining fluid balance is important. Thus, we do have the occasional patient going to surgery without having had an enema.

Tuinal gr. 3, or some similar sedative, is given h.s. in order to ensure a good night's rest for the patient. After sedation has been given, he is not allowed out of bed again. Tuinal may make some patients quite drowsy and accidents must be avoided.

The morning of the operation, the patient may be given a bed bath, because the presence of bacteria on his skin is a possible source of wound contamination. Following the bath, a clean gown is put on the patient.

Good oral hygiene is stressed from time of admission as it is the only available means of reducing the number of mouth bacteria. This precaution is especially essential before operations on the upper part of the gastrointestinal tract.

All patients must void just before going to the operating room. If surgery is being done on the female pelvic organs, the patient is catheterized and the catheter is left in, so that the bladder may be completely emptied in the operating room just before surgery. Vaginal hysterectomies and some vaginal plastics have vaginal douches, h.s. and a.m. The vaginal canal is painted with mercurochrome 2%.

The immediate preoperative standing orders regarding sedation used in our hospital are as follows: (1) If spinal, local, regional, nerve block anesthesia: morphine gr. ¼, atropine gr. 1/150 is given ¾ hr. preoperatively. (2) If intravenous, gas, general: morphine gr. 1/6, atropine gr. 1/150 is given ¾ hr. preoperatively. For a very ill, aged, or shocked patient, morphine 1/6 is given instead of ¼. Some doctors order their own special preoperative sedation. Many are using 50-100 mg. demerol instead of morphine.

Post-Operative Care

Following a spinal anesthetic, we do not elevate the foot of the bed as we used to a short time ago. Just as we stress adequate preparation of the patient, so we take special care to avoid post-operative complications.

1. *For pain*—demerol is used considerably, morphine in some cases, or procaine intravenously. The value of procaine lies in the fact that it relieves pain without acting as a respiratory depressant as does morphine. A new drug that is being used is methadon. It reduces pain only and has no local reaction following oral, subcutaneous, intramuscular, or intravenous administration. There is no interference with judgment or equilibrium—no respiratory depression. It is well tolerated—no nausea or vomiting. It is believed that it does not develop addiction.

The drug which relieves pain only, leaves our patient awake, free to move in bed which aids in post-operative recovery and avoids chest and venous complications.

2. To avoid *chest complications*, deep breathing is encouraged and, when advisable, supervised. Taking 10-15 deep breaths every 3-4 hours is considered essential. Carbon dioxide is administered 2-3 times daily and is given in sufficient concentration and duration to produce labored breathing. Also, early ambulation is an important factor in reducing chest complications.

3. *Urinary retention* is seldom a complication because of early ambulation. Following vagina' plastics, the patient usually comes from the operating room with a retaining catheter, as also in cases of radium implantation to the cer-

vix. This catheter is drained every 4-6 hours as a full bladder is to be avoided. It causes pressure to the wound area in vaginal plastics and there is danger of irritation to the bladder with radium. A fairly new drug called doryl is given in cases of retention. Doryl stimulates bladder tone. It is given intravenously or intramuscularly and is effective in 2-3 hours.

Following suprapubic prostatectomies the catheter is usually removed on the second day and the patient allowed out of bed. Occasionally, the patient has retention following removal of the catheter. If a retropubic operation has been done, the patient is kept in bed longer and has a retaining catheter 8-10 days. Following removal of the catheter the patient sometimes has difficulty in controlling urination for a short time.

4. *Venous complications* do not present the hazard that they did a short time ago. Bed exercises, frequent changes of position, and early ambulation are encouraged. Should a patient develop a thrombophlebitis, we have two drugs which act as anticoagulants. These drugs reduce risk and speed convalescence. Heparin acts by preventing the action of prothrombin and is effective in 2-4 hours. Dicumarol prevents formation of prothrombin but its action does not take place for 24-48 hours. If an immediate reaction is desired, heparin is given until dicumarol is effective. During the use of these drugs prothrombin time must be checked daily. The laboratory report indicates this in the form of a percentage. Fifteen seconds equals 100%, so 44 seconds equals 20-28%. Prothrombin time usually is not allowed to go below 30% because of the danger of hemorrhage. Dicumarol is given orally, heparin intramuscularly. Should hemorrhage occur, vitamin K is of no value. It may only be controlled by the use of whole blood or plasma.

5. With early ambulation *gas pains and distention* do not present the problem that so often used to accompany surgery. Sometimes a post-operative carminative enema is not even necessary on the third day. This is a happy situation both for the patient and the nurse.

6. *Fluid balance* is maintained by the administration of intravenous fluids if adequate fluid by mouth is not tolerated. With intravenous and gas anesthesia, nausea and vomiting do not present the problem that accompanied ether anesthesia. Persistent vomiting, however, is relieved by the use of gastric suction and fluid. Protein and vitamin balance is obtained by intravenous injection.

7. The Miller-Abbott tube was previously used in paralytic ileus. The principle involved was the continuous withdrawal by suction of the intestinal contents. The Miller-Abbott was a double lumen tube. Today we are using the *Cantor tube for intestinal decompression.*

The Cantor tube is a neoprene bag-tipped, mercury-weighted, single lumen tube (neoprene-plastic compound). The tube has the bag cemented to it. A tube 10 feet long will have two sets of four holes marked S. (stomach) at 17″, P. (pylorus) at 24″, D. (duodenum) at 30″.

The mercury is introduced into the bag through the last hole of the tube (5-10 cc.) by a syringe and needle. Air is expressed from the bag. The stylet of a 23-gauge hypodermic needle is placed in the tube in the area of the attachment of the bag to the tube. A single tie with heavy braided silk is then placed over this area. The tie is made sufficiently tight so that after the stylet is removed the mercury cannot escape from the bag nor can air enter it. However, should the bag become greatly distended with gas during a long intubation, the gas will escape through the small safety valve that has been created in the area where the stylet was placed during the tie. The neoprene bag has greatly reduced permeability of gas. Bags previously used acted as a semi-permeable membrane through which gas could penetrate and become so distended that on removal bags became detached.

The tube's movement down the alimentary tract is actuated by a combination of the free-flowing qualities of mercury and the peristaltic action on the bolus formed by the mercury in the bag. Mercury is given the maximum motility by the loose neoprene bag, thus utilizing to the

fullest extent the physical properties of mercury. Replacement bags are easily cemented on the tubes.

Pre- and Post-Operative Diet

Diet before operation is not restricted unduly although it should be light, highly nutritious, and easily assimilated for several days preceding, except in diseases of the gastro-intestinal tract. In these cases a special diet is ordered. Post-operative diets depend a great deal on the condition of the patient. Unless contra-indicated diets are increased quite rapidly, another factor in speeding post-operative convalescence.

Early Ambulation

It is impossible to say just when each surgical patient is likely to be allowed out of bed—that depends on the doctor and the condition of the patient. Two appendectomies may be done the same morning. One may be out of bed that evening and the other not for two or three days. Some thyroidectomies are out of bed the first day, others not for two days or more. Each patient is considered individually. Early ambulation has aided convalescence in many ways by preventing many complications. Also, there is little loss of muscle tone. Because the patient is out of bed early and feels quite well, he often acquires a false sense of well-being in respect to his health and resumes activities too soon. We stress the avoidance of such risks in our teaching.

We try to prepare our patient for discharge from the hospital. Each patient is considered individually and taught according to his specific needs.

Juvenile Diabetes

Sister Joseph Edmund, B.A., B.Sc.

Average reading time — 4 min. 48 sec.

Gordon, aged 2½ years, was admitted to the hospital on October 19, in the service of our chief pediatrician. He was in a very dehydrated condition. His face was extremely pale as well as the mucous membrane of his mouth and lips. He had a sore of long standing in the centre of his forehead and an infected finger which would not heal. The parents stated that during the past 18 days the child ate very often, drank much, waking up for a drink during the night, but that he lost weight nevertheless. He also voided very frequently. On admission he weighed 24 pounds but within a few days he lost another two pounds.

On the morning following admission, a fasting blood sugar and urinalysis were done. Blood sugar was 224 mgm. and the urine showed 1¼% of sugar and 2 plus of acetone.

A special diet, consisting of 159 grams carbohydrate, 58 grams protein, 40 grams fat, was ordered and was taken very well, along with forced fluids.

On the morning of the 21st, urinalysis showed 2¼% sugar and 4 plus acetone, plus a trace of diacetic acid.

Early on the morning of the 23rd, Gordon became very cyanosed and semi-conscious; respiration was very labored. He was placed in an oxygen tent. The house doctor was called and he made the following observations: "Acetone odor to breath; gums and tongue very dry; child cold and very drowsy. Impression—bordering on coma." Ten units of standard insulin were ordered and given immediately, followed by another 10 units in an hour. Forced fluids were ordered.

That morning a CO_2-combining

Sister Joseph Edmund is in the pediatrics department at the Ottawa General Hospital.

power test was done and found to be 28% whereas the normal is 53-70%. During the day the child was given a transfusion as well as continuous intravenous of saline with 5% dextrose. Ten units of insulin were given every six hours.

The next morning the urine was negative for sugar, acetone, and diacetic acid. Gordon was conscious and his general condition showed slight improvement. Continuous intravenous of saline and dextrose 5% was given during the day along with 10 units of insulin every six hours. He was given all the orange juice he could take.

By the morning of the 26th, Gordon was fairly well and urinalysis showed 1% sugar. Intravenous was discontinued and he was encouraged to eat light foods and to take orange juice. Frequent urinalyses were made during the following days and the insulin was decreased according to the result of these analyses and the quantity of food taken by the child.

On October 28 a hemoglobin estimation was done and found to be only 65%. A second transfusion was given on the 29th, on which day his blood sugar was 192 mgm., with general condition and appetite very much improved.

Gordon progressed very well until the morning of November 17 when he was listless, had no appetite, and his temperature began to rise. By 4:00 p.m. it had reached 103° and he showed a very slight rash on his body. It was thought that he was developing scarlet fever and that he should be moved to the Isolation Hospital. However, the chief pediatrician was called and, after examination, stated there was no danger of an infectious condition and to leave him where he was. He was given orange juice during the day to cover the insulin given in the morning. By midnight the temperature was down to normal and Gordon was on his way to recovery once more, much to the great satisfaction of all who took care of him.

This rather unusual occurrence was explained by the doctor as exanthem subitum or roseola infantum, a condition which usually consists of unexplained intermittent fever in apparently normal children under three years of age.

Medication given to Gordon during his stay at the hospital included penicillin cream applied to the sore on his forehead and his infected finger. Within ten days, as the child's blood sugar diminished and stabilized, these healed completely. After the second transfusion, Livifer was given him t.i.d. and his hemoglobin increased to 89%.

On two occasions during Gordon's hospitalization, he contracted a slight cold and showed a rise in temperature. He was given flocillin and everything cleared up rapidly.

Gordon left the hospital on December 11 with pink cheeks, looking hale and hearty. The first diet prescribed allowed him approximately 4½ grams protein per kilogram. He had put on weight during his hospitalization. Required calories for his age were adjusted to the rule which provides 1,000 calories as a starting point for

GORDON

a diabetic child, with an additional 100 calories per year of age. Adequate milk had been included in this diet, from the beginning, to furnish him with sufficient calcium for bones and teeth. His mother had followed a series of lectures given to diabetic patients at the hospital while her child was hospitalized. When given a copy of his diet, she was competent to take care of her child. He weighed 28 pounds at departure and was being given five units of protamine zinc insulin and five units regular insulin every morning.

Later his parents brought the child to see me. At this time he weighed 31 pounds, was 35 inches tall, and looked like a very normal child going on three, as may be seen by the accompanying photo. He told me about the birds at his home to which he gives "custs." When I asked him what they did, I was told that they "ting."

Gordon's blood sugar is checked regularly. Five units of protamine zinc insulin and five units of regular insulin take care of his present diet. This diet is sufficient for his growth and energy requirements for the present. It will be increased once or twice a year, according to his caloric needs, as he grows older.

Gordon is fortunate in having intelligent, devoted parents who are very attentive to his needs and he looks as though he will attain normal adult life.

Integration of Psychological Components into Pediatrics — Up to the Age of Two

ISABELLE GODEK

Average reading time — 10 min. 24 sec.

WHEN PERSONS choose nursing for a life work, in addition to their responsibility for achieving their own personal ends, they assume the obligation of guiding others. The emphasis in medicine is on prevention. The prevention of maladjustments, neuroses, psychosomatic illnesses and perhaps, to a great measure, even the psychoses, is dependent on having future generations of children brought up on sound psychological principles.

With the knowledge to which we now have access, it is easy to show that the moulding of this pattern of psychological principles into a human nature starts even before the child is born. From the time of its birth on, deep imprints are made in its impressionable response habits by human contacts. These fashion strong reaction patterns in the infant long before he is in any way responsible for them himself.

The nurse stands in the van of those who have an obligation and privilege to do something about directing the path of these reaction patterns. She is in a position to channel, and to explain the channeling, of emotional patterns that, once formed, will serve through life. It is, therefore, essential for her to understand these things herself and to explain them to parents before they take the baby and his future home with them.

The preparation of young women to assume these great obligations is the earnest task of those who teach them. Past experience of nurse-educators, as well as educators in other fields, gives ample evidence of the fact that integration of related branches of knowledge in a student's understanding cannot be left to chance or to a native intelligence.

In 1947 the U.S. Children's Bureau, together with the National League

of Nursing Education, sponsored a study[a] of pediatric nurses on duty. Among other results, they found that, in applying the basic psychological components to their work, neither student nor graduate nurses achieve hoped-for ends. It would appear safe to conclude that the integration of the psychological components in pediatric nursing was inadequately achieved. A plainer indication of the nurse-educator's duty could not be found. With these things in mind, the following approach to the teaching of a portion of pediatrics was prepared. It is an attempt to parallel the subject matter of pediatrics with related psychological components. Thus students may be helped to obtain a concept which would help them to understand the characteristics of an integrated personality. Understanding it, they may be able to put this knowledge into practice. None of these points is original—they are all abstractions from authoritative sources listed in the bibliography. The course outline follows:

The Nursing of Children

If a person wants to learn . . . it will help a great deal if he is given advance questions about the main points and about each point to keep in mind . . . a fairly clear preliminary idea of what it is about and what to get out of it.—James L. Mursell

Unit I (*5 hours*)

Orientation to the Study of Child Care

I—*Basic Historical Concepts* (2 hours)
- (a) Earliest history to the thinking of the last three decades.
- (b) Thirty years ago and up to the present concept—i.e., the psychobiological processes of growth and maturation.

II—*The Adjustment of Nursing Skills to the Care of Children* (3 hours)
- (a) Points of difference in children and adults:
  1. Emotional immaturity.
  2. Inability to reason.
  3. Psychological reaction to care by parents and strangers.
  4. Need for play.
  5. Nutritional aspects.
- (b) Mechanical and physical adjustments:
  1. Need for protection.
  2. Variety and size of equipment.
  3. Differences in facilities.

III—*Suggested Activities*
- (a) A written study indicating the differences in establishing rapport with adults and with children.
- (b) Motion pictures of appropriate topics.
- (c) Rounds of the children's wards in hospital. (Detailed orientation to specific departments reserved for time of clinical experience in the division.)

Unit II (*20 hours*)

Growth and Development of the Normal Child

I—*The Healthy Infant's Psychobiological Maturation*

Physical Aspects	*Psychological Components*
(Topical headings only—material not developed)	(As related to the topical headings of the physical aspects suggested)
A. The Newborn Infant	A. Components operating at birth—
	1. Influences of heredity.

A. The Newborn Infant (*cont'd.*)	2. Other prenatal influences: (a) Maternal state of mind. (b) Parental attitude to the coming of the child. (c) Other children in family. (d) Parental attitudes at birth. 3. Birth and the operation of consciousness factors: (a) Startle reflex. (b) Rooting and suckling. (c) Organ responses—i.e., hunger, discomfort, etc. 4. Environmental influences: (a) Baby's effect on persons and events of family activities. (b) Influence of family and others on the baby. (c) Existence and duration of undifferentiated nature of baby's first awareness. (d) Psychological implications of economic factors.
B. Physical Status and Developmental Data to the Age of Two Years	B. Development of differentiation in— 1. Emotional responses: (a) Synchronization of physical development with psychological responses. (b) Inner organ sensations and relation to formation of habit patterns. (c) Development in infant of channels for expressing self and his feelings. (d) Dynamic process of psychological growth; not just a series of shifts. (e) Danger of clinical distortions—e.g., vomiting, breath-holding, etc. 2. Social consciousness begins: (a) Importance of child's participation in the process. (b) Dangers of over-stimulation.
C. Nutritional and Physical Care Throughout	C. Awakening interests and curiosity with gradual loss of total helplessness— 1. Learning through developing sensitivities and increasing abilities. 2. Signs of readiness to feed self, wash self, etc.: (a) Necessity of cooperating. (b) Consequences of non-cooperation. 3. Toilet training: (a) Importance of correct timing. (b) Consequences of hurrying. 4. Unhealthy habits, as thumbsucking, ear pulling, masturbation, etc.: (a) Significance. (b) Methods of prevention.
D. Physical Needs in Environment	D. The importance of a happy childhood— 1. The effect of security and love on early self-control and proper adjustments. 2. Influences of parental discord. 3. Influences of inconsistent atmosphere. 4. Effects of parental attitudes on behavior of their children.

D. Physical Needs in Environment (*cont'd.*)

5. Influence of siblings:
   (a) Presence and danger of favoritism.
   (b) Jealousy and rivalry.
   (c) Love and acceptance.
6. The influence of all life experiences and emotional loads on personality:
   (a) Habits of eating.
   (b) Clothing that restrains.
   (c) Kind of discipline used.
   (d) Amount and kind of play.
   (e) Habits of hygiene, toilet, sleep, etc.

Ia—*Suggested Clinical Experiences in Conjunction with the Study of the Healthy Infant*

It is understood that these would be teacher-guided to point out contrasts and similarities.

1. The Well Child Clinic.
2. Experience in a home for infants.
3. Home visits to post-partum patients.
4. Study of the boarding-out system.
5. Experience in a nursery school.
6. Nursery school techniques on the ward.
7. Pertinent case studies and reports at seminars.
8. Pertinent reading references.

Unit III (*65 hours*)

Nursing the Sick Child

The principles underlying a child's healthful living are not changed by sickness. His needs are changed.—Gladys Sellew, B.S., R.N., Ph.D.

I—*General Nursing Care of the Infant*

Physical Aspects	*Psychological Components*
A. Admission to the Hospital with Related Nursing Techniques	A. The element of insecurity felt by both the parents and the child— 1. Establish relationship with parents and child which inspires trust and confidence. 2. Talk with the parents to learn about the family situation, child's personality and specific behavior responses. 3. Be certain to make adequate notes of this information for the use of others.
B. Getting the Admission History from the Parents	B. Recognize the need for parent education if it exists— 1. A baby's potentialities are born, not made. No parent should plan to transform him. 2. Give the baby security, affection, and supply intellectual needs and he responds with mental growth adequate for him. 3. Infancy is the period when emotional patterns that will serve through life are formed. 4. Quality of affection more important than quantity. Amount inversely proportionate to the age of child. 5. Child's behavior is expressed in terms of habit. The habit of responding with satisfaction leads to mental health and adjustment.

C. The Physical Examination

C. Promote security and reduce fears—
1. Child's emotional immaturity seen in:
   (a) Lack of self-control; displaying anger, crying, etc.
   (b) Dependence on loved ones. Parental attitude sets example for the child.
   (c) Consequent importance of reassurance to and rapport with parents.
   (d) Emotional excitement in child for small causes.
2. Child's mental immaturity shown by:
   (a) Inability to reason.
   (b) No sustained attention.
   (c) Fear of the new and the strange.
   (d) Problems of adaptation.
   (e) Life in the present moment.

D. Admission to the Ward and General Nursing Procedures

D. Modification of activities and equipment—
1. Consider child from viewpoint of:
   (a) Physical condition.
   (b) Developmental stage.
   (c) Family background.
   (d) Child's sex.
2. Additional considerations for infant:
   (a) Degree of helplessness.
   (b) Investigate meaning of cry—i.e., need for position change, discomfort from wetness, cold, hunger, pain, etc.
   (c) Remember, infant reactions form habit patterns which will serve through life.
3. Additional considerations for encouraging social consciousness in child:
   (a) Have a warm, friendly, sympathetic approach.
   (b) Keep language at level of child's comprehension.
   (c) Help child get acquainted with others in the room.
   (d) Give child a choice, where it is possible.
4. Psychological reaction to nursing care given:
   (a) Response as conditioned by general reactions to adults in the home situation.
   (b) Response conditioned by parental attitudes.
   (c) "Spoiled child" situations require patience. It is impossible to immediately alter the previous training.

E. Residency on the Ward. Observation an Important Part of Nursing

E. Interpretation of objective symptoms coupled with teaching—
1. Children can neither understand nor explain their difficulties.
2. Significant symptoms show themselves in:
   (a) Child's posture
   (b) Facial expression.
   (c) Body movements.
3. These signs appear as:
   (a) Languor, apathy, or crying.

E. Residency on the Ward. Observation an Important Part of Nursing (*cont'd.*)

(b) Refusal of food.
(c) Capricious desires.
(d) Sleeplessness or unusual character of sleep.

4. Anticipate child's needs and constantly be sure he really understands what is expected of him:
   (a) Let child know you like him.
   (b) Keep all promises made.
   (c) Care in the making of promises.
5. Provide for safety by:
   (a) Helping child realize what is safe in his environment.
   (b) Pointing out where he needs to use caution.
6. Encourage health habits:
   (a) Guide activities of hygiene.
   (b) Let child help self where it is possible.
7. Provide opportunities for learning experiences:
   (a) Play materials safe.
   (b) Adapted to age and ability of child.
8. Promote development of acceptable social behavior:
   (a) Friendly, informal conversation.
   (b) Express approval when occasion presents itself.
   (c) Help child become accepted by the group on ward.
9. Record behavior sympathetically, accurately, and concisely:
   (a) Evidences of independence.
   (b) Evidence of fears.
   (c) Special wishes and habits.
   (d) Generosity with belongings.
10. Note particularly such abnormal reactions as:
   (a) Irritability or restlessness.
   (b) Sensitiveness or shyness.
   (c) Jealousy, aggression, or cruelty.

II—*Specific Nursing Care*

This portion of Unit III should concern itself with the explanation of adaptations which have to be made to children of various age levels in giving nursing care in specific instances. For example:

Physical Aspects	*Psychological Components*
A. The Nursing of Children with Diseases of the Digestive System	A. Influencing attitude to food. The psychological approach to treatments, such as intravenous fluids, x-rays, and the like. Parent education in these matters.
B. The Nursing of Children with Diseases of the Respiratory System	B. Allaying fear in giving treatments such as oxygen therapy, croup tents, and the like. Making a game out of forcing fluids, etc.
C. Diseases of the Circulatory System	C. Making "staying in bed" a happy time, etc.
D. Diseases of the Glands of Internal Secretion	D. Building attitudes about such prescriptions as "no sweets" or "no salt and limited fluids."

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Penicillin Versus Silver Nitrate

HELEN CLAIRE HOWES

Average reading time — 3 min. 36 sec.

FOR MANY YEARS it has been required by law that silver nitrate be dropped into the eyes of each newborn baby. True there are many infants born in Canada without benefit of physician or nurse but every good attendant knows that this sterilizing process must be carried out as soon as possible after birth. The measure is, of course, a necessary precaution against infection of the baby's eyes if the mother should have gonorrhea—a frequent cause of blindness in the newborn.

If the mother suffers from untreated syphilis, the infant may be blind as well as diseased at birth. Gonorrhea, on the other hand, is not transmitted in the same way. During the birth process the gonococcus bacilli may infect the baby's eyes, resulting in blindness. Silver nitrate has doubtless saved the eyesight of countless numbers of infants. In this antibiotic age, it is possible to treat and to cure the mother during the period of pregnancy, thus ensuring the birth of a healthy baby. However, even if the mother is found to be completely free of venereal infection, no risk should be taken with the baby's eyes.

Within the past year or two, several reports have appeared in the medical press on the advantages of using penicillin rather than silver nitrate preparations as a prophylactic procedure. The studies involved large numbers of newborn babies. At the William McKinley Memorial Hospital in Trenton, N.J., the eyes of 251 babies were treated with penicillin. Two or three drops of sodium penicillin solution (of a potency of 5,000 units per cc.) were instilled into the conjunctival sac where it acted as a mild flushing agent. No further treatment was given unless there was evidence of infection. To check on the efficacy of the treatment, a conjunctival smear was taken immediately after birth; 24 hours later another smear was taken and still another on discharge from the hospital. The investigators found penicillin very effective indeed.

These doctors think it reasonable that penicillin should be more effective as a prophylactic measure than any of the silver compounds. Indeed, they are of the opinion that silver nitrate and other silver compounds have been thrown into disuse by the discovery of the sulfonamides and penicillin. It is particularly important, they emphasize, that penicillin be used in the eyes of those babies whose infected mothers have not been treated during pregnancy. The penicillin will render harmless any gonococcus or other Gram-positive organisms that may enter the eyes during birth.

Regarding the action of the penicillin, they point out that the sodium salt is not irritating and less likely to cause swelling or redness of the eyes. Certainly there is no danger of permanent injury to the cornea or conjunctiva. Moreover, it is not painful on instillation.

In another study at the Jefferson Medical College and Hospital in Philadelphia, 292 pregnant women were treated for venereal disease. Every baby received prophylactic silver solution and none developed ophthalmia neonatorum. However, another group of infected mothers went through their pregnancy untreated and, although their babies were also given the silver solution treatment, 16 of them developed infected eyes. The physicians, therefore, concluded that the most satisfactory means of preventing blindness in the infant born of a diseased mother is to treat the mother during her pregnancy.

The editors of *Obstetrical and Gynecological Survey* have commented on the conclusions reached in these studies. They believe that research of this type is of especial importance because of the widespread interest in discarding silver nitrate in favor of some form of penicillin prophylaxis. It was reported that in several series of cases where penicillin, in one form or another, was the preferred prophylactic agent against gonorrheal ophthalmia, out of over 6,000 babies not a single case of this form of ophthalmia occurred. More recently, local instillations of penicillin ointment have been tried. Many physicians pronounce this form of treatment the most satisfactory of all. It is possible that existing regulations, requiring silver nitrate instillations, may in time be modified to permit the use of some form of penicillin injections.

Just as the instillation of an agent into the baby's eyes is a routine measure, the treatment of the infected pregnant woman should likewise become a routine procedure, both for her own sake and for the well-being of her child.

Nursing in Formosa

A recent letter from Hildur K. Hermanson, a graduate of St. Paul's Hospital, Saskatoon, who is superintendent of nurses at the Mackay Memorial Hospital in Taipeh, Formosa, sheds some interesting light on nursing conditions in that teeming city:

"I was most interested in reading about the Metropolitan School of Nursing graduating their first class. . . Here we struggle along with what are little more than practical nurses. However, our hospital is giving a nursing service of sorts and the other hospitals are beginning to do it also. The first class of nurses from the government registered Provincial School of Nursing graduated this year—11 nurses and 30 midwives. They were all earmarked for government hospitals, public health work, etc., so we could not get one. Dr. Yen, Minister of Health, thinks that in 99 years there will be enough nurses for the work here!

"Stella Chen, who was in Toronto two years ago on a WHO scholarship, is director of nursing in the 500-bed University Hospital and is having quite a struggle beginning nursing service (instead of relatives) in that institution. She also now has a registered school for nurses—just begun—also a school for attendants (ward aides).

"On the staff we also have an English and a Norwegian doctor and two Norwegian nurses. It is a struggle getting ideas across. We are terribly busy—the number of patients increases faster than we can train people to cope with them. The present over-crowded conditions result in very poor hygiene."

The Adolescent Patient

AVIS PUMPHREY

Average reading time — 9 min. 48 sec.

ALTHOUGH THERE can be no hard and fast rules, it is safe to say that adolescents faced with serious illness need to focus at once on plans to be followed when health returns. This may seem self-evident but it is a point often missed by the busy professional people who become active on the youngster's behalf. The doctor pronounces the diagnosis and lays down the plan of treatment. The nurse sees that it is carried out. But what about the patient's reaction to his illness? His individual emotional needs are sometimes overlooked, resulting in perhaps a warped personality or hypochondriasis.

The adolescent diagnosed, for instance, as an active tuberculosis case is not just a body. He, or she, is the product of the environment. It is vitally important for the doctor, public health nurse, or medical social worker to know what this illness means to the patient and the use to which he is putting it, either consciously or unconsciously. He may not be able to tell you himself but you should be able to form an impression by thoughtful observation, insight gained through your relationship with the patient, and a growing understanding of his personal problems as he sees them.

Consider for a moment the shy, retiring lad who longs to be popular but never seems to make the grade. He does not get on the school team, he is unpopular at dances, does not know how to mix with others in his group. Serious illness may assume special importance, giving him a type of temporary prestige. He is put to bed, fussed over, sent flowers and gifts. Illness can be attractive—too attractive. He may be a delight to the nurse for he is a "good patient" who obeys all the rules. His chances of developing into an emotionally healthy young man, however, may be poor. Sickness is so pleasant that he may well develop "hospitalitis" and, though cured in body, be sick in soul.

More hopeful emotionally is the rebellious youngster who is the bane of his parents and the nurse alike. He refuses to admit that he is sick and escapes from the bondage of his bed at every available opportunity. The prescribed treatment is more distressing to him than the threatened consequences of his actions. He gradually becomes worse from the physical standpoint and is apt to develop violent aggressive feelings towards the world in general.

There are, of course, many other types of adolescent reaction to serious illness but the two mentioned are fairly typical. How can these youngsters be helped?

Time taken by all who are concerned in his care—to understand his reaction to illness—is time well spent. The first visits to the home are vitally important since they will lay the foundation for future relationships.

The nurse is, in the eyes of the patient, a figure of authority. As such she is apt to be the immediate enemy of the adolescent. Half child, half adult, he usually resents authority, whether he shows it openly or not. If the nurse falls into the trap of laying down rules for her young patient to follow, she is beaten at the start. That first visit should lay emphasis on establishing a firm foundation of mutual trust and confidence. It should not be a hurried interview. The ultimate goal should be to turn the young patient's eyes towards the future—that glorious time when he will be strong and well, able to take his place in the world. Treatment should be seen as a means of reaching this desirable goal. The wise nurse will discuss the whole matter with

Miss Pumphrey is director of the Social Service Department at the Montreal General Hospital.

the youngster, obtain his active cooperation, and *encourage him to make his own rules*. If he thoroughly understands the "why" of bed rest, special diet, relaxation, and so on, he will be more apt to see sense in what he is being asked to do and will willingly carry out the plan because he has participated in making it.

Illness, to those who work continually with sick people, is an old story. Finding the source of infection, checking contacts, and methods of protection are all stale with constant repetition. To the patient they may, however, be entirely new fields, full of interest and with fearful possibilities. The adolescent patient, in particular, is very apt to have strange pieces of misinformation that "somebody told him." These may be festering in his mind and it will take tact and much patient listening to learn of their existence. They need to be ferreted out, however, as they can do untold harm. This is particularly the case in hospital or sanatorium where some chronic patients seem to take a perverse delight in scaring newcomers half out of their wits with tales about the results of treatment. If the young patient has confidence in his nurse and a friendly feeling towards her, he will tell her of his fears and will accept her explanations.

Diagnosis of serious illness always comes as a shock to a patient. This should be realized and handled skilfully. A brushing aside of anxious questions with the comment that "You'll be all right—don't worry" is worse than useless. The patient *does* worry, no matter what you say, and worry is bad for him. Let him talk it out, however wildly he may behave in doing so. Be aware that he is probably in a panic and that he may not even remember later what he has said. A psychiatrist has stated that all patients receiving a serious diagnosis are mentally ill, even though the illness may be transitory, lasting only a few minutes. It is thus pointless to argue with such a patient or even to remember what he says. Allow the cleansing process of catharsis—"blowing off steam"—to take its course. When the panic has subsided, the patient will probably be able to face his problems more realistically. If he is paralyzed into silence by fear, encourage him to talk so that he may experience the relief of ventilating his feelings and not "blow up" emotionally later on.

The good nurse is a good listener. This usually requires much self-discipline since she is frequently anxious to do most of the talking herself. After all, she has health instruction to give and a lot of chores to do. If she wants to avoid endless repetition, however, she will listen more than she talks. This is straight common sense. If the patient has his attention firmly fixed on his own problems, he will be quite unable to hear the pearls of wisdom the nurse is letting fall, no matter how politely he may appear to be absorbing her every word. Much time is saved if the nurse uses restraint and allows the patient to control the interview until he has obtained emotional relief and found answers to his questions. Only then is he able to pay attention to other matters. This, it might be mentioned, is not a weakness of adolescents alone. It applies to his anxious mother and to every one of us. When we are under intense emotional strain, we are blind to everything except the matter about which we are presently concerned.

The public health nurse in a rural community may have few resources at her command. There are usually a few available, however, and these few grow in volume in the cities. As the nurse becomes aware of problems in the patient's home that are outside her immediate function, she will be wise to use these other resources. The most obvious one is, of course, the social agency. If there is a social worker available she should be invited to join the team for she will have her own contribution to make. That shy, inhibited youngster discussed earlier in this paper, for instance, would benefit greatly from sustained case work. The neglected child may be helped immeasurably by case work with the family. If the patient is troubled with deep feelings of guilt,

he may need help from the local priest or minister, or from a psychiatrist if one is available. If he is worried about losing his year at school, it may be medically permitted for the local school teacher to give him private tuition or the services of a visiting teacher may be available. Be aware of your patient's areas of need and try to meet them from community resources if possible. Such cooperative effort may be most effective in helping the patient towards physical and emotional health since it will help towards establishing peace of mind.

In keeping the patient's thoughts on the future, it is wise to remember that he is still a child, flexible as a willow wand. As long as he is planning for the future, it does not really matter if his ambitions change from week to week. Many of his ideas will be unrealistic but it is generally wise to let him work through the phases of wanting to be an engineer, a fireman, a soldier, or what have you. The important thing is that he wants to get well. The danger signal is lack of desire to be anything other than a sick child—pampered and petted. The difficult twofold goal must somehow be achieved—encouraging the patient to relax and accept treatment today while keeping his ambitions sharpened so that, when the time comes, he will be able to face the rigors of active life. The transfer from bed rest to convalescence and rehabilitation can be almost as traumatic as diagnosis itself—a fact not always realized—and careful preparation over a long period of time is necessary if success is to be achieved. Keeping the young patient's attention on rehabilitation from the very beginning seems to be the most effective method so far discovered to meet this problem.

Summary

To sum up the suggestions regarding the care of the patient:

1. Adolescent patients faced with serious illness should be encouraged to plan from diagnosis for the time when they return to health.
2. The meaning of illness should be assessed on an individual basis for each patient.
3. The shock of diagnosis should be handled through catharsis.
4. Areas of anxiety should be recognized and handled.
5. The young patient should be encouraged to understand his illness, accept its limitations, and make his own plan for treatment. Orders should not be imposed on him as he will only break them.
6. The twofold needs of the patient should be recognized: (a) relaxation and bed rest today; (b) ability to move from the sheltered life of the invalid into convalescence and normal activity in due course.
7. Community resources should be used where applicable.

Summing up observations made on the relationship between the nurse and the young patient:

1. The nurse represents authority, which may provoke hostility on the part of the adolescent.
2. A good relationship, based on mutual trust and confidence, is essential.
3. Self-discipline on the part of the nurse is exemplified in ability to listen patiently so that she may learn of the fears and anxieties, as well as the hopes and ambitions, of her patient.
4. Timing is important in teaching health measures, etc. The patient's areas of anxiety must be explored before he can pay attention to the nurse's teaching.

This is true also of the patient's anxious mother and of you and me.

This is by no means an exhaustive treatment of the problems involved when adolescents become seriously ill. It may, however, provide a basis for further consideration of this difficult and stimulating subject.

A measure of the revolutionary advances brought about by the so-called miracle drugs in the control of the infectious diseases is provided by the fact that for every person who dies of pneumonia now, three or four succumbed to the disease 15 years ago.

Lyle Creelman *Writes . . .*

Average reading time — 6 min. 48 sec.

DURING the first two weeks of October there was a hum of activity about the Hotel Noordzee in Noordwijk, Holland, which was quite different from the leisurely atmosphere of the regular summer season, for there were assembled the 42 nursing delegates and the staff for the Working Conference for Public Health Nurses of which I have written previously. The delegates were from 10 countries of Europe and they represented in the three main fields of public health nursing—teaching, supervisory, and staff. Although English was the official language of the conference, during free periods many tongues were heard because, of the countries represented, nearly all have their distinct language—although we must confess we did not hear our Irish delegates bursting into any other than their delightful brogue.

In spite of the high wind and rain which made flying difficult, nearly all had arrived by the first Sunday. The Dutch nurses, who were the hostess group, put on a delightful shadow-play using the most cleverly carved figures. One, of a nurse on a bicycle rushing to a family visit, was particularly intriguing. We were thus very amusingly and effectively introduced to our main topic for discussion during the two weeks—Health Education—and how the public health nurse can make her everyday teaching more effective.

At the Working Conference—nurses from Finland, Sweden, Belgium, Luxembourg, England, and Holland.

The conference was organized on the basis of having information sessions for the whole group, followed by small group discussions on the material presented and then report-back sessions. In the pre-planning for the conference the delegates had indicated their choice of subject matter and, in addition to health education, they wished to discuss nutrition and mental health. This was a lot of ground to cover. At the end we all decided that in a future conference we would limit ourselves to one subject. We had, in addition, special interest groups during the second week and among the topics discussed were staff education, the training of the public health nurse, conference planning, and the relationship of the public health nurse and the social worker. As in Canada, there is a keen interest in this latter topic and a general feeling that the two professions must plan and work closely together. As a matter of fact, in France and in Luxembourg, two of the countries represented, the public health nurse and the social worker is one and the same person—the "Assistante-Sociale."

Information Session on Mental Health, with Dr. Hargreaves, Chief, Mental Health Section, WHO.

This very difference in terminology is an example of the problems which may arise in a conference like this.

A report-back session

For example, a delegate from England, referring to the "district nurse," meant the nurse who carries the bedside nursing program. To the nurses from other countries this usually meant the public health nurse who did the family health teaching. We soon found also that the word "staff" did not mean the same thing to everybody. In Holland, for example, the word refers to the supervisory or administrative group. It was necessary to make very certain that we had the same understanding of the meaning of words. Frequently we English-speaking members were kindly but firmly told to speak "Not so fast, please!" We have only the highest admiration for those who can listen and converse all day in a language other than their mother-tongue. If you want really to know what it is to be fatigued, try it some day!

Not all the time was spent in discussion. On Saturday we had a delightful day in Amsterdam, starting first with a visit to the headquarters of the Health Department. Then we stepped out of the office of the Ministry of Health on to a boat which was one of the ambulances of the Amsterdam Health Department. We sailed along the canals to a fine modern centre for maternal and child health work. In the afternoon we were all taken on the regular canal trip which is a principal tourist attraction of Amsterdam. We were landed almost at the entrance to the Rijksmuseum where, with a guide, we saw some of Rembrandt's famous paintings. For some, the day had been so busy that the bus which waited at the door was soon away to Noordwijk full of weary nurses. A few of us, after a dinner at an Indonesian restaurant (of which there are many in Amsterdam), went to the Concert Hall and heard a fine concert played by the Vienna Philharmonic Orchestra.

Time out for tea—Miss Weddell, matron, Cassel Hospital (left) and three delegates from England.

Another interesting trip was to a flower market at Aalsmeer. The flowers are brought to the market by boats and auctioned to the highest bidder. You can imagine that a color photographer would go wild in such a setting—unfortunately, that was a day I had to stay home to work.

I must tell you also about a visit a few of us made to the Municipal Hospital in The Hague. Miss van Voorthuysen welcomed us in a beautiful new recreation room for the nurses and there on the wall I saw something which spelled "Canada" to me. Surely enough, it was a tapestry which had been presented by Miss Beyer and the nurses of Runnymede Hospital in Toronto.

One has to be away to realize what an opportunity Canadian nurses have had, and continue to have, to influence the professional development of nursing in other countries. At our conference, for example, many of the nursing delegates, leaders in their own countries, have studied under Miss Russell's direction at the Toronto University School of Nursing. Frequently, in our office, I hear or read of many nurses in other parts of the world who have been to Canada for study and have returned to be a real influence in the development of nursing programs in their own country.

Institutional Nursing

Transfusion Service

F. D. SIMPSON

Average reading time — 6 min. 24 sec.

AT THE Vancouver General Hospital, facilities have been developed, with the authority of the B. C. Medical Association, for graduate nurses to secure training and experience in the administration of transfusions and intravenous therapy. Lectures and explanations are given by the doctor who is assistant director of the hospital laboratories. Demonstrations and supervision are the responsibility of the head nurse in charge of the Transfusion Service. Nominally, the training period is two weeks, depending on the individual nurse's skill in mastering the techniques. No nurse is regarded as a qualified technician for at least three months.

The Transfusion Service is available from 7:30 a.m. to 11:00 p.m. The nurses work a straight 8-hour day, with the shifts divided as follows: 7:30-4:00; 8:30-5:00; 11:30-8:00; 2:30-11:00. The regular personnel policies of the hospital apply to the nurses on this service—namely, 1½ days off duty each week; all statutory holidays recognized; four weeks' vacation with pay; and accumulative sick leave reckoned on the basis of 1½ days a month after the nurse has been employed for three months.

At the present time there are six nurses on the Transfusion Service Team. A short summary of the work done during 1948 and 1949 will be an indication of the volume of the service:

	1948	*1949*
Transfusions	3,901	4,282
Plasma	370	427
Intravenouses	12,942	14,382
I.V. with medication	788	1,037
Restarts	1,401	1,173
Blood groupings	3,163	3,283
Adjustment calls	990	650
Total	23,555	25,234

It will be noted from these figures that the total of intravenouses and transfusions each year accounts for considerably more than half of our work. Other duties which are included in our responsibilities are: taking blood for cross matching, groupings, and Rh factor; recording blood received through the Red Cross, checking and signing out blood delivered to the ward messenger; checking returned bottles and noting clinical results; handling transfusion reactions, including obtaining and despatching necessary specimens for their full investigation; and so forth.

Each Transfusion Service nurse is provided with a kit that contains: a notebook and pencil, bandage scissors, artery forceps, bandage, adhesive tape, razor. The autoclaved needles, No. 19 and 22, and syringes, 2 cc. and 5 cc., are put up in sets, sterilized, and stored by the supply room. Autoclaved specimen tubes from the Red Cross complete the nurse's personal equipment.

On the ward she secures the tray containing alcohol, sterile swabs, and a syringe. Arm-boards and standards are part of each ward's regular equipment. The nurses on the ward are responsible for securing the bottle of solution ordered by the doctor, with the exception of blood which is taken directly from the refrigerator by the Transfusion Nurse. Ward equipment

Miss Simpson is in charge of the Transfusion Service at the Vancouver General Hospital.

also includes a delivery set containing the Vacodrip, tubing, and sterile needles.

When an order is written requiring the ministrations of the Transfusion Service nurse, the ward calls the Blood Bank where a record is noted of the time of the call, the ward, and the work to be done. The Transfusion Nurse, wearing her graduate's uniform and a badge labelled "Transfusion Service," signs out from the Blood Bank and notes the time she leaves for the ward. On arrival there, she records in her notebook: the patient's name and hospital number; the room number; solution and amount to be given which she obtains directly from the order written in the ward book.

The same routine is followed with each patient when the nurse reaches the bedside. After reassuring the patient regarding the treatment that is soon to begin, the Transfusion Nurse proceeds as follows:

Using sterile technique, remove outer aluminum band and cap from solution bottle, exposing rubber stopper which has one large opening for the Vacodrip and a smaller opening for the air-vent.

Insert Vacodrip into large opening and, if the air-vent opening is sealed, a sterile filtered needle is inserted to permit the solution to run.

Hang the bottle of solution on the standard, and remove air from tubing. Adjust rate of flow and level of fluid in drip-control apparatus. Clamp with artery forceps near adaptor.

Place patient's arm on arm-board. If there is a large amount of hair, the arm is shaved, with the permission of the patient. If the patient is nauseated or vomiting, the gown sleeves are removed from the arms.

Locate a suitable vein and place tourniquet approximately three inches above where the needle is to be inserted, making very sure tourniquet does not restrict arterial flow, by feeling pulse after pressure is applied.

Some equipment contains a glass adaptor, which may be attached before the needle is inserted. We use a 2-cc. syringe on the needle and attach metal adaptor after releasing the tourniquet.

Tape needle securely into place and tie arm on arm-board, restricting patient if necessary. Cover arm with towel. Check rate of flow.

Always leave patient as comfortable as possible, and place light cord within easy reach for calling nurse.

The nurse signs the ward book, noting the time the procedure commenced.

Very much the same procedure is followed in administering blood or plasma. In both treatments, a thorough check is made of the patient's full name, hospital number, and all particulars on the invoice issued by the Red Cross. The numbers on the bottle of blood and on the tag on the blood bottle must correspond with the numbers on the invoice. The actual procedure at the bedside is similar to that described. There is no air-vent in the blood bottle but one is provided in the Red Cross Transfusion giving-set. The stored and dried plasma is reconstituted with the necessary diluent, using strictly sterile precautions. The same kind of giving-set is employed as for a blood transfusion.

Ontario

The following is recent news concerning the Ontario Public Health Nursing Service:

Appointments—*Mary MacIlween* (Victoria Hosp., London; University of Western Ont. certificate course; B.S., Columbia University), formerly on the faculty of the University of Western Ontario School of Nursing, as senior public health nurse, North Bay board of health; *Frances Blue* and *Marion Van Exan* (Kingston Gen. Hosp. and McGill University public health course) to Peterborough board of health; *Mrs. Ellen Turpin* (S.C.C. Hosp., Surrey, Eng., and public health nursing cert., Royal Sanitary Institute, London, Eng.) to Leeds and Grenville health unit.

Resignations—*Betty Taylor* has returned to England after a year in Guelph.

Public Health Nursing

The Public Health Nurse and Mental Hygiene

ELEANOR M. HEADY, B.Sc.

Average reading time — 16 min. 48 sec.

THE FOLLOWING description of mental hygiene clinics in a generalized public health nursing service shows how a mental hygiene program in action can bring about, among nurses, parents, teachers, and others, a spread of the knowledge of the principles of mental hygiene and the development of a more tolerant and sympathetic attitude of mind. For the nurses concerned, this knowledge and attitude has made it possible to incorporate principles of mental hygiene in all phases of public health nursing.

THE HEALTH PROGRAM

The widely diversified needs of the public health program in the metropolitan area of Greater Vancouver are being met in part by a generalized public health service, with emphasis on prevention and health education. Each nurse in her own district is responsible for the public health nursing service in her schools, home visiting for school and child welfare, attendance at child health centres where she has conferences with the mothers of infants and preschool children, supervision of the tuberculosis cases and contacts living in her district, and supervision of other cases of communicable disease, including venereal disease. Teaching, chiefly incidental, in nutrition and mental health, is part of her program, too. She also refers children for correction of physical defects and dental care, for speech correction, for audiometer testing, for lip-reading classes, for sight-saving classes. Some nurses have kindergartens in their districts to supervise. The nurse is often called upon to speak to groups about some phase of her work and to direct the studies and discussions of small groups of mothers. She utilizes and cooperates with all the health organizations, social agencies, and recreational facilities in the community. On the Metropolitan staff there are public health nurses with specialized training, quarantine and sanitary inspectors, occupational therapist, craft worker, audiometrists, nutritionists, psychologist, dentists, psychiatrists, and medical health officers. In addition to her responsibility to her fellow workers and to the families in her district, the nurse has a responsibility for assisting in the training of future public health nurses through the university field work program.

NURSES NEED GUIDANCE

The public health nurses on the staff had long felt the need for expert guidance for themselves whenever they were confronted by situations where people did not act as ordinarily expected to—a tuberculosis patient stubbornly refusing to do what would obviously hasten his recovery; or children troublesome in school and a worry to their teachers and parents. Nurses who have graduated recently from schools of nursing have learned that the mind of the patient and not his body may be the source of his acute illness or the reason for his complicated convalescence. The ob-

Mrs. Heady is supervisor, Health Unit 2, Metropolitan Health Committee, Vancouver, B.C.

servant nurse sees how an actual illness may be a frustrating experience for a patient, causing him to deny even that he is ill; or an escape which brings the patient the attention he desires; or just another event to be met and dealt with to the best of his ability and the ability of those who rally around him, his family, his doctor, his nurse, his church, his social worker. Formerly, infant and child care in hospital was in many cases a strict adherence to schedules and orders. Hospital and university lectures in psychology and the care of children have only in latter years stressed the emotional needs of children and pointed out that nurses can relieve a mother's fears and promote security in parent-child relationships. Nurses are now taught to encourage parents to accept the child as an individual who will gradually achieve independence in action and thought and learn to live in harmony with his fellows.

Her professional preparation, her daily duties performed with understanding and observation, and her professional reading and in-service staff education give the nurse a background of knowledge of the development of the normal child. She is now often able to detect early signs of emotional maladjustment in children and, through teaching and discussion, usually with the mother, avert some serious future difficulties.

Mental Health Introduced

In 1932 the British Columbia Department of Health and Welfare instituted, as part of its preventive program, child guidance clinics in various parts of the province, including one in Vancouver. To this clinic the public health nurses, because of the limited facilities, could refer only the children with most urgent difficulties. It was a happy day in 1936 when the announcement was made that there would be a mental hygienist on the staff of the Metropolitan Health Committee.

The majority of children referred to the mental hygiene clinics the first few years were, of course, the classroom nuisances and the children who were considered potentially delinquent. Teachers and nurses expressed their disappointment when, after each clinic, the children behaved no differently than before. This was especially true when, after the nurses had persuaded the parents and teachers to try the suggestions made by the mental hygienist and to show affection, give encouragement and praise, the children were even more troublesome than before their referral. Jim was still a bully and Marie still would not apply herself to her studies. The nurses and teachers did not realize, of course, that in long-standing difficulties, where parental care had been harsh, the change to a more tolerant treatment would find the child testing his newly found freedom and apparent acceptance in the family circle and in the classroom.

It was obvious that all persons concerned with child welfare required much factual information about normal reactions and normal development and above all a tolerant and understanding outlook. It is hoped that this is gradually being achieved through these same mental hygiene clinics and through a program of staff education.

The present staff for the mental hygiene clinics consists of the director of the Division of Mental Hygiene, his assistants, and a psychologist. It is hoped that shortly facilities and additional staff will be available in order to provide play therapy and assistance in speech and reading. There is need also for a psychiatric social worker and a nurse consultant to help individual nurses in mental hygiene, especially new staff nurses and students. The latter two positions will, we hope, be filled before long.

Finding the Clients

Who is referred to the mental hygiene clinics? As the service is a preventive one, the patients are chiefly children from elementary schools, some from junior and senior high schools, normal school, and university; a slowly increasing proportion of preschool children and a few infants. Nurses are

becoming more aware of those mothers at Child Health Centres who need special instruction and reassurance.

In 1949 a total of 380 children were seen in the Metropolitan Health Committee mental hygiene clinics. Among this group were 47 preschool children. A further 180 children, who had been seen previously as new cases, were seen for follow-up. These figures are from the 1949 annual report of the mental hygiene division of the Metropolitan Health Committee, as are the other statistical data in this article.

The child's visit to the mental hygiene clinic is initiated in many cases by the public health doctors and nurses who, during school examinations, child health centre conferences, or during home visiting notice signs of emotional maladjustment. Some referrals are by workers from social agencies in the Metropolitan Health Committee and some from the Vancouver School Board attendance department. During recent years more and more cases are being referred by teachers and principals, by parents themselves, and by the family doctors. The publicity given in the past few years to mental health in the press, radio, movies, and from the platform has made many parents less self-conscious and less apprehensive in discussing their children's development with the public health nurse. Unfortunately, there still are many who feel there is some disgrace in going to a psychiatrist and that, by going, they admit failure in their responsibilities as parents.

In 1949 the schools referred 121 pupils, health unit doctors and nurses, 87 children, parents 75, private doctors 50, social agencies 18, and school board workers 14. At the mental hygiene clinic of the Health Centre for Children in connection with the Out-Patient Department of the Vancouver General Hospital an additional 34 children were examined after referral by other physicians at the Centre.

Change in Types of Cases

With the gradual expansion of the mental hygiene clinics in the past few years, proportionately fewer children with delinquent and aggressive behavior and more children with psychosomatic conditions and symptoms of tension are being seen. These difficulties were noted in the 510 children seen at the clinics during 1949:

Poor group adjustment	202
Poor school progress	157
Attention-seeking behavior	114
Negativism	89
Tension	88
Disturbance of elimination	73
Seclusiveness	56
Stealing	51
Absences from school	45
Over-dependency	44

In order of frequency noted, these problems were also present: overactivity 42, speech difficulties 39, worries 38, inferiority feeling 37, fears and night terrors 35, temper tantrums 34, day-dreaming and use of phantasy 30, nailbiting 25, feeding problems 23, tics, tremors, and choreiform movements 23, disturbances of consciousness 21, neurotic use of symptoms 20, assault tendencies and bullying 20, weight disturbances 19, reading disability 19, respiratory conditions 17, gastrointestinal disturbances 16, skin conditions 16, thumbsucking 16, delinquency 14, sleeping problems 13, headaches 12.

It was interesting to note in the director's annual report the large number of children under tension and with psychosomatic conditions, children who in most cases live in areas which, because of the good housing and high standards of living, could casually be classified as presenting no problems at all for the district nurses. The challenges to nurses in many instances are not dirt and poverty and ignorance about disease but the anxiety and competition which is the way of life for many ambitious couples seeking security for themselves and advantages for their children.

Initial Steps

What is the procedure that culminates in a mental hygiene clinic

session after the nurse is approached by a school principal about a pupil, Tommy, who is apparently not adjusting well to the everyday problems of his life? She first clears with the Social Service Index to find out if other agencies are interested in Tommy's family. She learns from the school principal and classroom teacher about Tommy's school progress and behavior. In the school districts where there is a psychologist, Tommy would have an individual intelligence test at school. Tommy is seen as soon as possible by the medical officer at school; his health record may contain previous entries helpful in considering the total picture. If Tommy's parents have had him in the care of a family physician, the health unit director discusses the situation with him and they decide together about the referral. Then during careful interviews in the home the public health nurse gathers relevant data so that she can write a summary for the mental hygienist about Tommy and his family.

The public health nurses are encouraged to discover for themselves why a child acts as he does and to try to determine for themselves what his innate tendencies may be, his temperament, his physique, his intelligence, what his environment lacks to promote his wholesome development towards maturity, and what features are present that can be built upon to promote mental health. A nurse is inclined automatically to shrink from anything that she feels is in a doctor's realm—namely, anything smacking of diagnosis and treatment—but when she remembers that she is actually trying to get a complete picture of the child—his background and his present environment—and keeps in mind basic facts of any child's development, then her data present themselves fairly logically as cause and effect.

If when clearing with the Social Service Index the nurse finds that Tommy's family is known to a social agency, contact is made with that agency in order to pool the information and decide on the next step. If the social worker is visiting the home, she may prepare the summary for the mental hygienist and make arrangements with the family for the visit to the clinic. If the family is not known to a social agency and it appears that the problem is such that referral will be necessary, the appropriate agency is consulted beforehand by the unit supervisor and invited to send a worker to attend the conference.

Preparation for the Visit

Needless to say, both Tommy and his parents need to be prepared for their visit to the mental hygienist. The parents need to have explanations in simple terms why they are going and the possible extent of the assistance they can expect. They need to realize that the easing of Tommy's problem still remains with them; that their visit to the clinic and their further discussion thereafter with the public health nurse, teacher, or social worker are for support and direction of the parents' own thinking so that they can make their own plans and personally carry them out. The parents are told, too, that the child's teachers and nurse will be meeting with the psychiatrist and social worker in order to help Tommy; that the family doctor will be consulted, too, and recommendations discussed with him.

Tommy is prepared for his visit to the clinic by his parents as well as by his nurse. The mental hygienist is described as a doctor, especially interested in children, how they get along at school, at home, and in all their other activities. To tell Tommy that the doctor wants to find out why he is so shy and steals will not promote a happy relationship at the clinic. Tommy is reassured, however, when he is told that the doctor will be able to help him to be happier. Tommy loses some of his fears when the nurse describes the clinic to him, the building, the people who may be there, things he may do, the interesting puzzles or reading with the psychologist, and the fact that he will be able to see the doctor all by him-

self and will be able to tell him everything he wants to.

Arrival at the Clinic

When Tommy and his parents arrive at the health unit on the clinic day, the boy is interviewed first, then his parents, who are usually seen separately. Tommy has a physical examination and has a friendly chat with the psychiatrist. He is then seen by the psychologist who has equipment for intelligence tests for children of various ages. The atmosphere is friendly and the child usually at ease. It is hoped that in the near future a suitably furnished playroom will be part of each health unit, thus permitting fuller observation of the child.

In a morning at the mental hygiene clinic it is usually possible for the psychiatrist to see two children new to the clinic and then to see their parents or else to see one new child and his parents and one or two who have been seen on previous days and are referred again for follow-up. In the afternoon another child new to the clinic may be seen and also his parents, or perhaps two children and parents originally seen at some previous clinic session.

The Clinic

The nurse's information about the child, his home, his neighborhood based on her knowledge of her district, the social worker's summary, the report from the family doctor, and the psychologist's findings are all placed before the psychiatrist to aid him in assessing the individual he is to see and the home conditions. When the child is with the psychiatrist he often talks about his difficulties quite freely. Thus he can be more readily reassured and shown what he himself can do about his problems and the effects they may be having at home and at school. When the mother or father are interviewed there is further education. The parent discusses the situation, airing his views. Eventually he understands the cause of the child's difficulty. Then he can begin planning to help his child. Only one or two interviews may be needed for some parents and children, in addition to the public health nurse's follow-up in the school and in the home. Other parents and children require many interviews. Some are beyond the scope of a service which is intended primarily for education and prevention.

Staff Conference

After the last patient has been seen the mental hygiene conferences start. It is found that one-half to three-quarters of an hour should be allowed for each conference. The public health nurse, the social worker (if a social agency is visiting the family), the child's teachers, and the school principal come in from the district to the Health Unit Office to talk with the mental hygienist. At this conference the psychologist is present, too, the health unit director and school medical officer as often as possible, and occasionally the family doctor. In some instances workers come from the School Board Bureau of Measurements or Attendance Department. If the child attends private school, a similar conference is held with the child's teacher and principal coming to the Health Unit Office. If the child is preschool age and attends a kindergarten, his kindergarten teacher may be present.

The conference, with the mental hygienist in charge, starts off with a review of the circumstances that brought about the referral of the child. The innate tendencies of this particular child are brought to light as are the pertinent factors in his present environments of home, school, and community. The conference, too, is educational in nature for facts about the normal development of this particular age group are reviewed incidentally, as are the basic principles that apply in this particular case. Each worker is encouraged to participate in the conference, not merely by giving further descriptions of the child's actions but in helping the entire group to arrive at a fuller understanding of the situation. During the conference various plans are brought up, discussed, and finally

a course of action is decided upon with each worker taking a share of the responsibility for the follow-up that is indicated. Needless to say, at each conference the observant workers gain something either in factual knowledge or in point of view that can be applied to future situations.

Reports on Conference

After every clinic day a written report on each clinic examination and conference is sent out by the mental hygienist for the various workers directly concerned with the child—namely, to the health unit office for the information of the unit director and public health nurse; to the school for the information of the principal, teacher, and medical officer; to the social agency if one is concerned; and one to the family doctor where there is one.

Some of the Results

The courses of action that were taken in 1949 by the mental hygienist, following the conferences on the children, are condensed in the following table:

Follow-up at own mental hygiene clinics	165
Referral of child to other clinic for psychiatric treatment	8
Referral of parents for psychiatric treatment	7
Referral of child to private physician for medical treatment	30
Referral for social agency supervision	31
Referral for social agency casework	18
Foster home placement	23
Supervision by probation officer	3
Supervision by recreation activity	22
Vocational guidance and training	33
Academic adjustment	39
Certification to mental institution	12

The discussion with parents and teachers, actually the most important part of the treatment, was held in all cases and so is not tabulated.

The following are some of the pertinent factors that were found to have a bearing on the child's behavior:

Significant background factors	30
Unsatisfactory family standards	25
Broken homes	84
Housing difficulties	13
Overt parental rejection	146
Style of parental care	358
Sibling rivalry	130
Illness and injury	24
Constitutional factors: physical	42
" " : temperamental	39
" " : intellectual	56

Among background factors considered were the conditions of pregnancy and delivery, family history of related complaints, and cultural and racial clashes. Style of parental care was found in 9 cases to be spontaneous and affectionate, anxious in 202 (too solicitous, 85 or too rigid, 117), inconsistent in 113, too lax discipline in 3, and too harsh discipline in 31. Physical constitutional factors included neurological and endocrine disabilities. The temperamental deviations included the active emotionally labile, those with poor energy output, the sensitive withdrawing child, the aggressive, the perseverative.

Again referring to the director's annual report, out of 380 children seen by the mental hygienist none was diagnosed as psychotic; 12 were diagnosed as having a psychosomatic condition; 20 adolescents had special need for guidance; dull-normal and border-line intelligence were found in 42; mental deficiency in 21; epilepsy in 9.

Carrying Out Plans

It is usually the public health nurse's responsibility to see that the teachers and parents understand the child's real problem and how it causes him to act as he does. It is her responsibility, too, to encourage the teachers and parents to carry out plans through which the child will grow into a well-adjusted adult. Further visits of the child or parents or teachers to the mental hygiene clinic may be indicated and are arranged usually by the public health nurse. About every six months she sends the mental hygienist a report on the child. She must assess how well all concerned—the mother, the teacher, the nurse herself—understand

the underlying principles they have learned and if these are evident in their handling of the child in his environment. Where a social agency is active, the nurse and social worker try to keep each other informed of major developments and further conferences may be necessary. Cases are kept under observation by the nurse for as many years as may be considered advisable for the child's adjustment. At the same time statistics are gained that will prove the effectiveness of this preventive service.

Another factor the nurse needs to learn to assess is the relationship she builds up with the individuals she deals with. She must determine for herself what sort of individual she has just met and, above all, how that individual is reacting to her. The insecure mother, for example, meeting her district nurse for the first time would only be made more insecure, guilty, afraid, and possibly antagonistic by the nurse's impersonal and thorough questioning about Cynthia's enuresis, the mother's apparent favoring of a younger brother, and the nurse's insistence that a visit to the mental hygienist is urgent. The relationship that the nurse carefully builds up between the mother and herself and the relationship she supports and maintains between the mother and the mental hygienist often determine whether or not the child will be helped at all.

Applying the Principles

The nurse in her interviews with parents, children, teachers, and others can apply the principles she has gradually learned. The mental hygiene program in action means more to her than merely an interesting and stimulating phase of public health nursing. The nurse knows herself better, gains in confidence for herself and in compassion for others. Even if she cannot solve the many vexing situations she meets she searches more carefully and sympathetically and eventually may understand them. She gradually realizes why Mr. Brown with positive sputum refuses hospitalization and exposes his family to infection; why Minnie cannot lose any weight; why everyone complains about that awful Ted. In fact, there is scarcely a situation in the nurse's public health duties in her contacts with children, parents, teachers, and fellow workers where she cannot apply what she learns in the mental hygiene conferences.

Dr. John R. Rees, director of the World Federation for Mental Health, in an address, "International Amity Begins at Home," published in the January, 1950, issue of *Mental Hygiene*, tells of the importance to the child of early influences in the home and community and the necessity for suitable education for all people who deal with children. He states: "The child who grows up able to live and to love and to cooperate in the home and the family will quite certainly be an adult able to love his neighbor as himself; and his neighbor is not merely the man next door but also the man on the other side of the world."

India's Need for Nurses

A Canadian nurse writing us from India wonders if there are any Canadian nurses who would be interested in going there to work. She says in her letter: "There would be a need for any fully qualified nurses but those trained in teaching and supervision are most greatly needed. Books for student nurses, nurses' libraries, and instructors are also an urgent need.

"There are several times more doctors than nurses in India. In this province of Orissa, which has a population almost equal to that of Canada, there are only about 50 trained nurses. There are only three small training schools. Please tell the nurses."

She suggests that any nurse who is interested should write to *The Secretary, Indian Nursing Council, c/o Directorate General of Health Services, New Delhi, India*, or to the Mission Board of her own church.

Aux Infirmières Canadiennes-Françaises

Lobotomie et Nursing

FERNANDE RIVERIN

LA PSYCHIATRIE d'aujourd'hui ne se résigne plus dans une attente à analyser les syndromes psychopathologiques et leur évolution. Chaque jour le psychiatre moderne s'aventure avec de plus en plus de hardiesse thérapeutique, l'homme savant a entrepris une lutte pour dominer la nature et conquérir la santé. L'hôpital psychiatrique moderne a adopté dans ses services les techniques nouvelles; personne ignore les merveilleux résultats de l'électrochoc, de l'insulino-thérapie, de la psychothérapie, de l'occupation-thérapie dans le traitement des maladies mentales. L'infirmière 1951, toujours en éveil devant le progrès scientifique touchant à sa profession, connaît déjà l'application sensationnelle de la psychochirurgie à la psychiatrie et sa valeur importante.

Des auteurs de tous les pays ont abondamment écrit en ces derniers temps sur ce thème remplissant de nombreux volumes d'observations, expériences techniques, découvertes, etc. La psychochirurgie est dans une période de croissance, un peu tâtonnante peut-être, mais pleine de promesses. Sujet très vaste et captivant, dépassant je m'en excuse les limites de mon expérience.

En mars dernier, lors de notre journée d'études, le Dr Cabana, chirurgien à l'Hôpital St. Jean de Dieu, nous a brillamment exposé les diverses techniques opératoires de la lobotomie et complétées par des projections lumineuses, illustrant ses données de façon très précises.

Conférence donnée par Mlle Fernande Riverin, I.L. spécialisée en psychiatrie, à l'Hôpital St. Jean de Dieu, Montréal.

Qu'est-ce que la lobotomie? C'est une intervention chirurgicale qui consiste en une trépanation bilatérale des pariétaux, quelquefois unilatérale, dans le but de sectionner les faisceaux blancs d'association qui unissent le cortex préfrontal au reste du cerveau et en particulier du noyau médiodorsal du thalamus.

Cette technique fut inaugurée en 1935 par Egaz Moniz au Portugal. En 1936 Freeman et Watts répandirent la lobotomie en Amérique y apportant certaines modifications. Depuis lors cette intervention est de plus en plus en faveur. Au Canada on la pratique depuis 1946.

La lobotomie est indiquée pour:

La schizophrénie; les grandes obsessions; la mélancolie anxieuse; les troubles graves du caractère avec réactions antisociales chez certains épileptiques; les algies psychiques; les algies somatiques; la grande anxiété avec agitation et impulsions violentes.

A Montréal, il semble que seuls les déments précoses aient été soumis à la lobotomie. Les malades sélectionnés pour cette intervention sont parmi ceux qui ayant résisté à toutes autres thérapeutiques, sont considérés demeurer chroniques. Il est aussi préconisé que l'évolution des troubles mentaux n'aura pas dépassé trois ans. Cependant à St. Jean de Dieu certains malades étaient à l'hôpital depuis, 7, 14, et même 22 ans et ont donné un spectacle très encourageant d'une amélioration qui persiste encore après un an. Certains aliénés pouvant bénéficier de l'amélioration d'un symptôme — par exemple, faire disparaître ou amoindrir l'agitation ou encore le fait de délivrer un malade de la contrainte serait une raison

suffisante pour tenter l'intervention. Le sujet jeune est meilleur candidat mais encore on a observé des malades dépassant 55 ans, donner preuve d'une récupération satisfaisante. De toute façon l'âge ne devrait pas compter comme contre-facteur.

Barahona Fernandès signale une action plus favorable de la lobotomie dans la mélancolie que la manie. D'autres auteurs affirment que la lobotomie abolit la périodicité des accès et d'autres admettent plutôt que certains de leurs malades opérés ont des phases diminuées, atténuées plus courtes et plus espacées. Les déprimés après l'intervention peuvent montrer une période légère d'hypomanie. Pour revenir à Barahona Fernandès je cite: "L'attitude optimiste, la dispersion, la tendance à la fuite des idées persistent chez le maniaque opéré mais son comportement est amélioré." Freeman et Watts rangent certaines névroses d'angoisse à expression psychosomatique et certaines douleurs intenses dans laquelle la composante émotionnelle paraît comme secondaire à des lésions somatiques (tabès, cancer), Dans la psychose hallucinatoire chronique le délire persistera.

Les malades non recommandés pour la lobotomie sont: les psychopathes, les alcooliques, les morphinomanes, les homosexuels ou autres déviations sexuelles, les pervers, et les arriérés mentaux. On éliminera également les malades souffrant d'hypertension artérielle, de cachexie trop avancée, et de processus encéphalitique en évolution.

Qu'elle doit être la préparation d'un malade proposé pour la lobotomie?

1. *Electro-encéphalographie méthode* dont l'application permet de dépister les anormalités de l'écorce cérébrale et d'en caractériser la forme; ainsi on peut découvrir si ces ondes anormales sont de type épileptique ou non et arriver de façon précise à localiser le foyer épileptique ou autre.
2. *Examen mental* aussi précis que possible; additionné des tests d'intelligence et de personnalité.
3. *Examen physique* complet comprenant les analyses du laboratoire, la radiographie des poumons, etc.
4. *Enquête sociale.* On ne saurait trop insister sur l'importance de ce point.

Toujours se rappeler que le but ultime de la lobotomie est de restituer à son milieu social un malade qui, même guérit, ne sera jamais l'individu d'avant sa psychose. Il faut connaître les conditions de ce milieu, la mentalité de sa famille, son attitude ou ses préjugés devant la maladie de notre aliéné. Mettre bien en évidence les conflits ou problèmes qui ont peut-être participé au déclanchement de l'accident psychique. Quelle sera la compréhension de son entourage? Sera-t-il capable de collaborer à la réhabilitation sociale du malade et de continuer en quelque sorte le travail commencé à l'hôpital? Le patient enfin trouvé apte au traitement chirurgical sera transféré dans le département réservé à cet effet.

Ici je me permets d'ouvrir une parenthèse. Il serait idéal que l'hôpital psychiatrique possédat une unité strictement réservée à ces malades. Dans cette section tout le personnel aurait profité d'un entraînement spécialisé en vue de la tâche à accomplir auprès des malades lobotomisés. Chaque matin, par exemple, après la lecture du rapport de nuit, il serait bon que l'infirmière en charge discutat la condition des malades, le programme destiné pour chacun, le rôle de chaque employé envers tel malade, le processus post-opératoire des nouveaux opérés, etc., attirant l'attention des étudiantes, mettant en évidence les symptômes à observer, l'amélioration notée, etc. Quinze minutes suffiraient pour créer une orientation enthousiaste au travail de la journée et l'infirmière aussi bien que le malade en profiteraient. Le médecin du service pourrait présider une conférence chaque semaine où tous les membres du personnel seraient présents. Chacun rapporterait ses observations. L'aide, qui aurait conduit le patient au parloir, décrirait le comportement de celui-ci. La technicienne de l'occupation thérapeutique donnerait un compte-rendu de sa conduite durant le travail et ses progrès. Ainsi de suite et de cet en-

semble résulterait un tableau illustrant bien l'état au cours de la journée entière de notre lobotomisé, mettant en relief ses capacités et dans le cas contraire éclairerait sur d'autres perspectives. Le médecin indiquerait à chacun ses directives et notre malade bénéficierait d'un intérêt collectif et d'une récupération plus rapide.

Pour revenir à la *préparation immédiate* d'un cas de lobotomie, elle est en tout semblable aux autres interventions chirurgicales du fait que l'on doit s'en tenir à l'observance rigoureuse des prescriptions du chirurgien. On rasera la tête avec un rasoir bien aiguisé, évitant les égratignures du cuir chevelu; propreté parfaite de le région et aseptie rigoureuse; le lavement évacuant, la veille, les sédatifs préopératoires, etc. Que le travail soit exécuté avec minutie, se rappelant qu'une préparation bien faite éloigne toujours des possibilités de complications.

Préparation morale: Elle diffère des autres opérés en ce sens, qu'étant en face de déments précoces il semble inutile d'expliquer la raison de l'opération au malade cependant. Ici, comme toujours, l'infirmière usera de tact et de bon sens. Tout l'entourage dépensera auprès du malade toutes les ressources de bonté et de sympathie auxquelles il a droit.

Le prêtre visitera le malade la veille de l'opération quelque soit son indifférence. La famille, qui sera instruite et aura consentie à l'intervention, se fera un devoir de passer quelque temps auprès du malade le jour précédent l'opération. Bien noter l'attitude affective envers les siens à ce moment dans le but de comparer plus tard.

Soins Post-Opératoires

A son retour de la salle d'opération on aura un soin particulier de bien supporter la tête évitant la moindre secousse. Ici le rôle de l'infirmière est de tout premier ordre: Surveiller étroitement le malade tant qu'il reste sous l'effet de l'anesthésie et ne pas quitter sa chambre. Position dorsale; à son réveil élever la tête du lit si ordonné par le chirurgien. Changement fréquent de position pour faciliter la circulation. Tenir compte du pouls, respiration, température, tension artérielle, couleur des téguments et tout noter. Etre en garde au cas où apparaîtraient un symptôme neurologique; convulsions, tremblements, paralysie, Babinski, trismus. Surveiller les réactions pupillaires. Ne pas perdre de vue les pansements. Généralement on installe un sérum glucosé I.V.

Les complications sont plutôt rare mais il est prudent d'avoir l'appareil d'oxygène à portée de la main. Une chute de tension artérielle, avec un pouls rapide, est un indice de choc. Pression artérielle élevée et un pouls lent fait penser à une pression intracrânienne. Une température très élevée, rebelle à une médication antibiotique comme la pénicilline, doit donner l'éveil.

L'hémorragie interne apparaît parfois dans les premiers 24 heures. Une agitation croissante, suivie par un état de somnolence allant parfois jusqu'au coma, est un signal d'alarme. Les convulsions accompagnées d'inégalité pupillaire indiquent souvent les premiers symptômes d'une thrombose. A ce moment on note généralement une élévation de la température avec un pouls ralenti et diminué de volume ainsi qu'une respiration endessus de la normale. Quelque soit le symptôme anormal ne pas hésiter, avertir immédiatement l'interne ou le chirurgien suivant la gravité. Les douleurs et l'agitation seront calmés par les sédatifs prescrits. Les bonnes paroles ont aussi un effet remarquable pour tranquiliser notre malade. On note de la confusion au début qui persistera quelques jours.

Le lobotomisé nous apparaît alors à un stade de l'enfance d'où il faut lui réapprendre les notions les plus élémentaires de la vie. L'infirmière, s'occupant de ces malades, doit auprès d'eux jouer le rôle de la mère. Il s'agit de rebâtir un individu; elle doit en quelque sorte le pousser vers la réalité et cela dans tous les domaines.

On lève le malade le premier jour de l'opération, un peu plus longtemps

les jours suivants et plus souvent. Mesurer ses efforts à ses forces. Le malade sera souvent porté à l'inertie; le forcer à rester debout. S'il peut manger seul, l'encourager à le faire mais le surveiller pour qu'il ne s'étouffe pas avec ses aliments. Il semble presque général d'observer de l'incontinence chez ces opérés. Il faut procéder au dressage et, dans la majorité des cas, des efforts vigoureux et constants combattent rapidement cet état de chose. Par exemple: régularité des habitudes, passer les malades à la toilette à l'heure fixe, etc., ont vite fait d'entraîner le malade à la propreté. Cependant un petit nombre de malades continuent à être gâteux, signe assez probable d'une amélioration retardée.

(*La suite au prochain numéro*)

In the Good Old Days

(*The Canadian Nurse, January 1911*)

"How frequently one hears the phrase: 'The noble calling of the nurse.' In reality, true nobility is not in the occupation, whether such occupation be that of a trained nurse or a scrub woman. True nobility will be found only in the soul of the individual. It is an individual charm. The nurse can, by self-sacrifice and devotion to her work, make her life career a noble one or, by contrary methods, she can make it one of the most debased and ignoble careers imaginable.

"The calling of the nurse differs from some other callings, not in any special nobility but in the special opportunities for doing things called noble."

* * *

"It is with deep regret that we say farewell to our editor, Dr. MacMurchy, who has been a staunch friend of the nurses so long and who has done such splendid work in establishing *The Canadian Nurse*. When Dr. MacMurchy first consented to do this work it was with the understanding that a nurse would be found as soon as possible to take it over. She has completed her sixth volume."

* * *

"The Legislation Committee of the Graduate Nurses' Association of Ontario has had a proposed Registration Bill drafted. They recommend that we go forward to try to obtain legislation at the next session of the Provincial Legislature."

* * *

"Lavinia L. Dock has done well a difficult and necessary task in her new book 'Hygiene and Morality'—a manual for nurses and others, giving an outline of the medical, social, and legal aspects of the venereal diseases. Such a book has been needed this many a year. Nurses should all read it, if only to be able to protect themselves."

Homogenized Milk

Milk is homogenized by being forced through small apertures under high pressure. The result is that the fat is broken up into minute globules so that it remains dispersed throughout the milk instead of rising as cream. This process was first instituted in the province of Quebec in 1909 but it is only within fairly recent years that the popularity of this form of whole milk has reached even measurable quantities. It is roughly estimated that 10 per cent of all milk consumed today is homogenized.

Homogenization ensures the full cream value of the milk to children in the home where the cream in the bottle might otherwise be poured off for some other use. Claims made for the easier digestibility of this form of milk have been substantiated by numerous tests. The smaller curds that result when homogenized milk is used speed up the process of digestion because there is a much greater area of contact between the fat globules and the digestive juices. Thus it may be recommended with assurance, especially for infants and young children and elderly people.

Nursing Profiles

An interesting project that will have far-reaching implications for nursing in Canada is being launched by **Pauline Jewett.** Announcement has been released of her appointment as director of the Structure Study of the Canadian Nurses' Association. Eminently suited, both academically and personally, to undertake the research which is required in a study of this nature, Miss Jewett will begin her work this month.

A Canadian, Miss Jewett graduated in arts from Queen's University, Kingston, Ont. Post-graduate work for her master's degree was taken at Radcliffe University. She secured her Ph.D. at the London School of Economics where she has been engaged in research work.

The Canadian Nurses' Association is to be congratulated on the celerity with which they have put into effect the resolution sponsoring this study which was passed unanimously at the convention held last June.

Announcement has been made of the appointment of **Ellen Johanne Broe** as director of the Florence Nightingale International Foundation. A graduate from Bispebjerg Hospital, Copenhagen, Miss Broe was granted a fellowship by the Danish State Health Department in 1936. She studied hospital administration and teaching in schools of nursing at Teachers College, New York. She received a three-month travel grant from the Rockefeller Foundation in 1947 and studied the integration of public health into the nursing education program at the University of Toronto School of Nursing and at various universities in the United States.

ELLEN J. BROE

Miss Broe has had broad international experience. She has worked in England, France, Holland, and the United States as well as in her own country. Since 1938 she has been director of post-graduate courses at the Post-Graduate School for Nurses, Aarhus University, Denmark. From 1941 to 1946 she served on a committee set up by the Danish Council of Nurses to study the status of nursing education in Denmark. The report was eventually submitted to the Minister of Internal Affairs.

On four occasions Miss Broe has been a delegate from the Danish Council of Nurses to I.C.N. congresses. These opportunities to have met and conferred with nurses of many lands will prove valuable in her new international contacts. From 1946 until the reorganization of the F.N.I.F. she served on the Committee of Management and the Educational Committee of the Foundation. She was elected a member of the new Florence Nightingale International Foundation Council which held its first meeting in March, 1950.

The future holds great possibilities for the Foundation under its new director. Miss Broe will have the good wishes and warm support of her friends and colleagues in Canada.

Esther Jane Robertson has been appointed as an assistant to the chief superintendent of the Victorian Order of Nurses for Canada. Her move to the National Headquarters culminates a series of steady progressions with the V.O.N. since she first joined the Montreal branch. A graduate in 1933 of the Royal Victoria Hospital, Montreal, Miss Robertson secured her public health nursing certificate from the McGill School for Gradu-

ate Nurses. She also has her B.S. degree from Teachers College, Columbia University, New York.

A native of Wetaskiwin, Alta., Miss Robertson joined the Order 14 years ago. During four of the nine years in Montreal, she was supervising nurse of the North District. In 1945 she was appointed as national supervisor of the V.O.N. western branches.

ESTHER ROBERTSON

Margaret Ferne Trout is creating a new function for the Registered Nurses' Association of British Columbia as itinerant instructor. In this role she visits the nurses in their own communities, bringing them word of current developments, new trends, and new methods in nursing.

Teaching has been Miss Trout's primary interest since she completed her course in teaching and supervision and received her B.A.Sc. degree from the University of British Columbia in 1944. Born in Arcola, Sask., she received her preliminary education in B.C.,

FERNE TROUT

graduating in arts in 1939. Her professional training was taken at the Vancouver General Hospital. Subsequent experience has taken her into the field of tuberculosis, emergency department, and eye work. An omnivorous reader, Miss Trout enjoys golf and travelling. She should have ample opportunity to indulge this taste in her new work.

Laura Margaret Attrux is now instructor in the course in advanced practical obstetrics, sponsored by the University of Alberta. Of French descent, Miss Attrux was born at Duck Lake, Sask. She graduated from St. Paul's Hospital, Saskatoon, in 1930. Her special interest in obstetrical nursing was evident early in her career when, after two years as nursing arts instructor at her own school, Miss Attrux became obstetrical supervisor at Holy Cross Hospital, Calgary. By

LAURA ATTRUX

1939, the district nursing service had won her away from hospital activity. Isolated communities in Alberta needed nursing and maternity service. With no physicians available, the special skills which Miss Attrux brought to the patients demonstrated the need for the advanced practical course to train other nurses. In addition to her public health training at the University of Toronto, she has further prepared herself by work at the New York Maternity Centre Midwifery School and the Frontier Nursing Service and Midwifery School at Wendover, Kentucky. Miss Attrux is currently stationed as district nurse at Mirror Landing. An amateur photographer who is also interested in fishing, gardening, and music, she is living for the day when she can learn the favorite winter pastime of curling.

Still on active duty after 59 years in nursing is the unique record of **Caroline Sewell** who is a general staff nurse at the Toronto General Hospital. A graduate of Queen Charlotte's Hospital, London, Eng., Mrs. Sewell specialized in midwifery and attended many hundreds of confinements in her work in Britain. Moving to Canada with her family in 1908, they settled in a small community in northern Ontario where Mrs. Sewell responded to the frequent calls for her nursing skills. When her invalid husband died in 1928, she moved to Sarnia, Ont., where she found plenty of work to keep her occupied. She has been nursing in Toronto for the past six years, always happy that, despite her 79 years, she still can make a contribution to the profession she has served so long.

In Memoriam

Lulu Evelyn (McLean) Clarke died in Brockville, Ont., on October 4, 1950, in her 58th year. Mrs. Clarke retired from professional activity many years ago. She had been in ill health for some time.

* * *

Edna May (Bremner) Harrington died in Hamilton, Ont., on October 12, 1950.

* * *

Sister Marie Florence Harwood, who began her nursing service with the Religieuses Hospitalières de St. Joseph in 1895, died in Montreal on October 16, 1950, at the age of 78. Sister Harwood was with Hotel Dieu in Montreal during her entire career.

* * *

Helen (MacDonald) Johnston, a graduate of Charlottetown Hospital, P.E.I., was killed in a tragic air accident in the French Alps on November 13, 1950. Mrs. Johnston was stewardess on the aircraft.

* * *

Charlotte Macleod who, as the first chief superintendent of the Victorian Order of Nurses for Canada from 1897 to 1903, was instrumental in laying the splendid foundation on which the outstanding work of the Order has been built, died at her home in Winchendon, Mass., in October, 1950, following a long period of failing health.

Born in New Brunswick in 1852, Miss Macleod taught school for several years before going to Waltham, Mass., to enter her training. The training included considerable experience in district nursing which was invaluable later to Miss Macleod. She spent over six years as superintendent of nurses there. In 1896, she was granted a five-month leave of absence to study district nursing in Great Britain under the direct supervision of Florence Nightingale.

Following her resignation from the V.O.N. Miss Macleod returned to the United States where she remained active in organizational positions until her retirement in 1916.

* * *

Mary McKenty, formerly matron at the Ontario Hospital, Hamilton, died on October 23, 1950.

* * *

Loie Mersereau, who graduated from Chipman Memorial Hospital, St. Stephen, N.B., in 1922, died at the age of 58 at her home in Hoyt, N.B., after a long illness. Miss Mersereau had engaged in private nursing for a number of years before becoming night supervisor at the Chipman Memorial Hospital. She served in that capacity for 12 years before ill health necessitated her retirement.

* * *

Rachel Clarke Moon, who graduated from the Toronto General Hospital in 1916, died in Toronto on October 17, 1950. Miss Moon had spent most of her professional life in private nursing in Toronto.

* * *

Elizabeth H. Purdy, who graduated from the Toronto General Hospital in 1905, died in Toronto on October 17, 1950. Miss Purdy

Randolph Macdonald, Toronto

ELIZABETH H. PURDY

was supervisor of the Private Patients' Pavilion, T.G.H., for 30 years. She retired in 1944.

* * *

Minnie (Borden) Shaw, a native of Pugwash, N.S., who had spent her professional life working in the United States, died recently.

* * *

Muriel Simpson, who graduated from the Regina Grey Nuns' Hospital, died in Winnipeg on October 17, 1950, at the age of 54. Miss Simpson served overseas during World War I. Upon her return to Canada she worked for three years with the Manitoba Department of Health and Public Welfare before joining the staff of the Margaret Scott Nursing Mission. In 1928, she joined Winnipeg's public health services with the Division of Tuberculosis Control. Later she was appointed public health nurse at Fort Rouge, Man.

* * *

Louise (Craig) Sprott, a graduate of the Lady Stanley Institute, Ottawa, died suddenly at her home at Johnson's Corners, Ont., on October 28, 1950.

* * *

Dorothy Steel, who received her training at the Toronto Hospital for Incurables, graduating in 1914, died recently in Montreal after a brief illness. Almost her entire nursing career—33 years—was spent in active duty with the Montreal branch of the V.O.N.

* * *

Stella Marion Jane (Mooney) Stutt, who graduated from the Ontario Hospital, London, in 1930, died in London on October 29, 1950, at the age of 43.

Personnel of C.N.A. Committees

CANADIAN NURSING is entering upon a very important phase of development and every Canadian nurse has a particular responsibility to work with her association in order to give it the support of her considered thinking. Especially is this true of the committee members whom you have elected or chosen to do the work of the Canadian Nurses' Association for the coming biennium. They are your spokesmen—the people who will do the work, who will accept the responsibility, and who will formulate the policies.

Are you going to make them feel that you are 100 per cent behind them by an awareness of problems and a willingness to express an informed opinion? Committee work brings with it many privileges not the least of which is individual growth; but it also brings hard work, long hours, and sometimes frustration. In this big country it is difficult for National Committees to come together and a large part of the work must be done by correspondence. This method is slow, time-consuming, and not always too satisfactory but, in spite of difficulties or perhaps because of them, the National Committees accomplish a tremendous amount of work. It is they who are on tiptoe to know what must be done and to seek ways and means of doing the job. Never did we need well-informed, energetic, actively-supported committees more than today. Let us now introduce you to the people

who will be working with and for you during the next biennium. A National Office secretary is a member of each committee. The president of the C.N.A. is a member, *ex officio*, of every committee:

NATIONAL COMMITTEES

Committee on Constitution, By-Laws and Legislation: Miss N. D. Fidler (Ont.), chairman; Miss I. Broadfoot (Man.), Mrs. D. McKeown (N.S.), Miss M. B. Millman (Ont.), Miss L. E. Pettigrew (Man.), Sr. M. St. Albert (Ont.), Miss A. Wright (B.C.).

Committee on Educational Policy: Miss E. Mallory (B.C.), chairman; Miss A. Wright (B.C.), secretary; Miss N. D. Fidler (Ont.), Miss M. E. Hart (Man.), Miss A. J. Macleod (Ont.), Miss H. Mussallem (B.C.), Miss A. E. Reid (Ont.), Sr. M. Claire (B.C.), Miss M. Street (Que.).

Committee on Finance: Miss G. J. Sharpe (Ont.), chairman; Miss E. Stuart (Ont.), vice-chairman; Miss F. H. Walker (Ont.), secretary; Miss E. M. Cryderman (Ont.), Miss M. Mathewson (Que.), Sr. M. Grace (Ont.).

Committee on Health Insurance: Miss E. Robertson (Ont.), chairman; Miss A. Girard (Ont.), vice-chairman; Miss E. Young (Ont.), secretary; Miss H. Carpenter (Ont.), Miss M. Henderson (B.C.), Miss M. Myers (N.B.), Sr. Denise Marguerite (B.C.).

Committee on Institutional Nursing: Miss M. E. Macfarland (Ont.), chairman; Miss C. M. Adams (Ont.), Miss B. M. Beyer (Ont.), Miss E. Honey (Que.), Sr. M. Kathleen (Ont.), Sr. Saint Paul (Que.).

Committee on Labor Relations: Miss I. Broadfoot (Man.), chairman and secretary; Miss E. J. Wilson (Man.), vice-chairman; Miss N. D. Fidler (Ont.), Miss H. M. Lamont (Que.), Sr. Paul du Sacré-Coeur (Que.); a general staff nurse.

Committee on Private Nursing: Miss N. Malone (Que.), chairman; Miss M. Baker (Ont.), Mrs. E. Brackenridge (Ont.), Miss J. G. Brown (Alta.), Miss K. MacKenzie (B.C.), Sr. M. Ursula (Ont.), Miss M. Wood (Que.).

Committee on Program: Miss H. G. McArthur (Ont.), chairman; Miss H. M. Carpenter (Ont.), Miss S. Giroux (Que.), Miss T. G. Hunter (B.C.), Miss M. E. Macfarland (Ont.), Miss B. Pullen (Man.), Miss G. J. Sharpe (Ont.), Sr. Jeanne Forest (Que.), Miss M. Street (Que.), Miss F. Verret (Que.).

Committee on Public Health Nursing: Miss H. M. Carpenter (Ont.), chairman; Miss M. L. Palk (Ont.), vice-chairman; Miss G. Charbonneau (Que.), Miss J. DeBrincat (Man.), Miss M. E. Hunter (N.B.), Miss L. F. Miller (B.C.), Sr. M. Amata (Ont.), Miss M. I. Walker (Ont.).

Committee on Student Nurse Activities: Mrs. L. Kelly (B.C.), chairman; Miss J. Mackie (Alta.), vice-chairman; Mrs. M. Botsford (B.C.), secretary; Miss D. Dick (Man.), Miss M. E. Kerr (Que.), Sr. Catherine Gerard (N.S.).

SPECIAL COMMITTEES

Canadian Florence Nightingale International Foundation Committee: Miss E. K. Russell (Ont.), chairman; Miss B. M. Beyer (Ont.), Miss N. D. Fidler (Ont.), Miss G. J. Sharpe (Ont.).

Exchange of Nurses Committee: Miss N. S. Mackenzie (Que.), convener; Miss E. C. Flanagan (Que.), Miss M. C. Livingston (Ont.), Miss A. J. Macleod (Ont.), Miss E. L. Moore (Ont.), Miss B. Pullen (Man.), Sr. Jeanne Forest (Que.), Miss M. Street (Que.).

Joint Committee—Canadian Hospital Council and Canadian Nurses' Association: C.N.A. representatives: Miss M. Macfarland (Ont.), Miss M. Mathewson (Que.), Miss M. Russell (Que.), Sr. M. Felicitas (Que.).

Loan and Bursary Committee: Miss H. M. Lamont (Que.), convener; Miss I. Black (Que.), Miss A. Girard (Ont.), Sr. Valérie de la Sagesse (Que.), Mrs. S. R. Townsend (Que.).

Committee on the Provision of Nursing Care: Miss N. D. Fidler (Ont.), convener; Miss E. Cryderman (Ont.), Miss T. G. Hunter (B.C.), Miss M. Myers (N.B.), Sr. Denise Lefebvre (Que.).

Committee on Public Relations: Miss M. C. Livingston (Ont.), convener; Miss M. E. Kerr (Que.), Miss E. A. E. MacLennan (N.S.), Miss E. K. McCann (B.C.), Miss M. J. Schoales (Ont.), Sr. M. Kathleen (Ont.), Miss P. Stiver (Ont.).

Committee on a Structure Study of the

Canadian Nurses' Association: Miss F. H. M. Emory (Ont.), convener; Miss E. Cryderman (Ont.), Miss N. D. Fidler (Ont.), Miss M. Myers (N.B.), Miss E. Paulson (B.C.), Miss B. Pullen (Man.), Sr. Denise Lefebvre (Que.).

E. Frances Upton Fund Administration Committee: Miss E. M. Stuart (Ont.), convener; Miss S. Giroux (Que.), Miss J. E. Jamieson (B.C.), Sr. Catherine Gerard (N.S.).

Editorial Board for "The Canadian Nurse": Miss M. Mathewson (Que.), convener; Miss I. Black (Que.); third member to be ratified at next Executive Committee meeting.

Amazing Push-Button Hospital Bed

Marvel Beem, M. D., who began to practise in Westwood Village in 1926, exhibited his versatile invention to leading hospital administrators and physicians at the annual meeting of the American Hospital Association, September 18-21, 1950, in Atlantic City. He describes the amazing hospital bed as "the biggest news in patient care since Florence Nightingale."

Startling Features

The bed, which possesses such different features as a built-in toilet bowl connected to the sewage system, a mobile lavatory with hot and cold running water, and a trapeze which enables a patient to shift position unaided, all available at the touch of a push-button, is the fourth model developed by Dr. Beem. A Fellow of the American College of Surgeons and a graduate of the Loma Linda Medical School, Dr. Beem declared that the installation of his ingenious invention in hospitals and homes would benefit hospitals and patients.

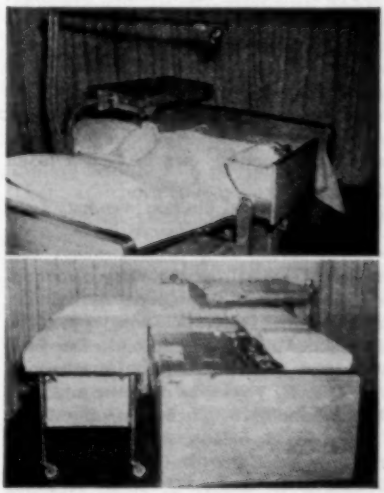
Operated by Patient

The primary value of the bed to hospitals, since it can be operated either by patient or the nurses through a system of buttons on the tray, would be economic in nature. The inclusion of the bathroom facilities eliminates the need for the majority of hospital bathrooms, Dr. Beem asserted, and renders the traditional bed-pan obsolete.

Dr. Beem said that the hydraulically operated bed is a big step toward relieving the current shortages of trained nurses. The invention will improve the lot of the patients confined in hospitals or bedridden at home.

Patients will be more comfortable, happier, and will be able to rehabilitate themselves more rapidly. The bane of all hospital patients, the compulsory pre-dawn awakening, could be eliminated because most patients could complete their morning ablutions unaided and in a brief time be ready for scheduled breakfast.

A patient placed on a Beem Bed for the first time would be amazed at the many functions available merely by pushing a button on an attractive tray. One button



Revolutionary Hospital Bed

This completely new type of hospital bed can be operated by patient using push-buttons. According to its inventor, the bed, which includes bathroom facilities, will relieve nurses of many duties and free them for more serious cases and also give patient a feeling of greater comfort and self-reliance while hospitalized.

elevates the head of the bed, another, the lower portion of the bed below the knee, and a third, the entire bed from 23 inches above the floor to a maximum height of 32 inches.

Other push-buttons also activate the following functions:

Trendelenburg and reverse Trendelenburg; oscillator circuit; self-contained guerny (cart); retractable trapeze with reading light and enema standard. The tray is adjustable for eating or reading and it contains 500 cubic inches of space for personal articles. There is also a compartment for adequate linen storage.

For further information regarding specifications, financing, delivery dates, and service write to: *The California Darlington Co., Beem Bed Division, 11702 Mississippi Ave., Los Angeles 25, California.*

—HARRY E. CALKINS

Nursing Sisters' Association of Canada

The annual luncheon of the *Ottawa Unit* was held on November 11 in the Quebec Suite of the Chateau Laurier. E. Pepper, the president, received the 54 members and the honored guests. Grace was said by Rev. Serson Clarke and an enjoyable meal followed. The guest speaker was Col. J. N. B. Crawford, M.B.E., E.D., senior consultant to the Director General of Medical Services in Canada. Many facts concerning the possibility of an atomic bomb attack on any large Canadian city were brought before the gathering. This talk aroused much interest as Col. Crawford stressed the importance of medical and nursing care in such a major catastrophe.

The 19th annual business meeting of the Unit was held at Trafalgar House with the president in the chair. Sixty members were present. Reports from the various committees were read and approved. M. Kitchen gave a résumé of the 12th biennial convention of the N.S.A.C. held in Vancouver last June. A Theatre Night is planned for February, with Mrs. E. Vowles as convener and Mrs. W. Sharpe and Miss Kitchen assisting.

The following officers will serve during the coming months: President, E. Pepper; vice-presidents, D. Percy, G. Scott; recording secretary, F. Garnett, 310 Holmwood Ave.; membership secretary, D. Dent, 54 Somerset St. W.; treasurer, M. Kemp, 20 Clarey Ave.; service convener, E. Bagnall; social conveners, Mrs. J. H. Stitt, D. Lodge; councillors, E. Schryer, F. Nevins, Mrs. H. J. Coghill.

The *Prince Edward Island Unit* joined in the annual Armistice Day Service when a poppy wreath was laid at the War Memorial in Charlottetown by W. Schuman and M. MacDonald. In the evening the Charlottetown Hotel was the scene of the fourth annual dinner meeting when 19 members were present. Various committees were appointed and it was decided to send a Christmas gift box to be distributed among English nurses. "Ditty bags" were also to be made for veterans in hospital, in cooperation with the Canadian Legion.

The Unit president is Marcella MacDonald with Mona Wilson serving as vice-president. Marjorie Cox was re-elected as secretary-treasurer.

Premenstrual Tension

Emotional tension occurring before the onset of menstruation is generally believed to be due to an edema of certain tissues, including the brain, that is brought about by retention of salt and water which, in turn, is produced by the relatively large quantity of estrogen circulating at this stage in the menstrual cycle. The ammonium chloride treatment carried out during the last two weeks of the menstrual cycle has two important phases: (1) restriction of the sodium intake and (2) administration of ammonium chloride in doses averaging two grams daily. This means avoiding the use of salt at the table and also avoiding sodium bicarbonate and other alkalinizing drugs and saline laxatives. Very rarely will women fail to respond to this treatment; however, it gives results only during the current period and must, therefore, be continued indefinitely.

—*Physician's Bulletin*

Trends in Nursing

Average reading time — 4 min. 48 sec.

Active Minds

IN NEW YORK last year a prominent business speaker told his audience: "The most arresting developments in adult education the world over are taking place in Canada." In 1949 a Canadian delegation returned from Copenhagen where it represented Canada at a world conference on adult education. Friends in Europe have reported that at this conference no country made a more impressive contribution than Canada.

UNESCO has a division for adult education which plans conferences, distributes information about films, books, art and music of interest to adult leaders, and is working on co-operative approaches to ending illiteracy in undeveloped countries. A Canadian, Eugene Bussière, is now head of this adult division.

Canadians have played an active part as participants and staff members of these conferences and in loaning specialists for educational projects. A number of adult leaders in other countries have spent time in Canada studying methods and techniques. The Canadian Association for Adult Education is now giving a good deal of time to this work with UNESCO and is keeping in touch with the adult education movements in Great Britain, the United States, the Commonwealth, and Scandinavian countries especially.

Why should any nurse go to the bother of studying? Because it is one of life's saddest days when a man or a woman admits he or she is past learning, or boasts that he doesn't have to learn any more, or just declares he is too lazy. Hal Burton said it wisely in a recent issue of *Better Homes and Gardens:* "You have a Model-T type mind if you've lost interest in learning . . . if you skim through the newspaper, confine your radio listening to purely entertaining shows, rarely read a book, and never develop a new hobby." Or, as H. A. Overstreet remarked in his book "The Mature Mind": "An adult who ceases after youth to unlearn and relearn his facts and to reconsider his opinions is like a blindfolded person walking into a familiar room where someone has moved the furniture." What could a nurse hope to get out of adult education? In a sentence: You could hope to find answers to your own problems and to have national and world problems made understandable. One of the outstanding features of a man's life in the modern world is his conviction that his life-work as a whole is neither fully understood by himself nor fully understandable by any of his fellow men. Adult education, study in groups, just talking things over—these will help integrate a man or a woman.

The conference method of adult education is an effective way to keep people's minds active. As long as men have had others with whom to talk they have engaged in debate and the exchange of ideas. The virtue about today's adult education forums is that the talk does not dribble into conversation. The people who attend them are there to learn and they carry away with them clearer ideas of the issues they choose to debate.

How can adult education help nurses nationally? By helping individual nurses to think straight. Everyone wants the reputation of being broadminded. That does not mean being a pleasant listener but one who keeps his mind open on a question until the evidence is all in and, moreover, insists on the best evidence.—Adapted from *Questions and Answers,* Canadian Association for Adult Education.

Nursing Schools at the Mid-Century

A report by experienced nurse educators and sponsored by the national nursing organizations of the United

States is a *must* for every nurse administrator in Canada. This book presents a word picture of practices in schools of nursing as of today. In 1948 the six national nursing organizations set up a Joint Committee to develop programs for the improvement of nursing service. The first task, as seen by the committee, was an examination of current practices in basic nursing education. A Subcommittee on School Data Analysis was formed for this purpose and this attractive daffodil-yellow book tells the nursing profession in terse and colorful terms where we stand *today*. As conditions in the United States closely parallel those in Canada, this report should be of great value to Canadian nurses.—Published by *The National Committee for Improvement of Nursing Services*, 1790 Broadway, New York City 19.

An Analysis

A short article on the importance of bedside nursing and the relationship between good nursing care and the general duty nurse recently came to our attention. The author asks the following pertinent questions: Why do nurses tend to think bedside nursing menial? Have we stressed the importance of supervisory positions to such a point that a nurse hesitates to let it be known that she is "still" doing general duty? Have hospital administrators failed to emphasize and show the importance of general duty nurses? Are we offering them opportunities for interesting professional growth and progress? Are we offering financial security? Are we offering emotional security, social security? For further details, read *The Modern Hospital*, October, 1950, issue.

Executive Committee Meeting

A meeting of the Executive Committee of the Canadian Nurses' Association will be held on February 8, 9 and 10, 1951, in the Viceregal Suite of the Ritz Carlton Hotel, Montreal.

Orientation et Tendances en Nursing

LES ESPRITS EVEILLÉS

A New York l'an dernier un homme d'affaire important s'adressa à son audience en ces termes: "A travers tout le monde c'est au Canada que l'on développe le programme le plus intéressant pour l'éducation des adultes." En 1949, lors d'une conférence internationale sur l'éducation des adultes, la délégation canadienne, au dire des gens, fit par sa contribution une impression plus grande qu'aucun autre pays.

L'UNESCO a une division de l'éducation des adultes qui prépare des conférences, distribue des renseignements sur des films, des livres, l'art et la musique, susceptibles d'intéresser des adultes. En travaillant en coopération elle espère en finir avec l'ignorance dans les pays-arriérés. Un canadien, Eugène Bussière, est le chef de cette division.

Bien des dirigeantes de d'autres pays sont venus au Canada, afin d'étudier nos méthodes et nos techniques sur place. L'Association canadienne pour l'Education des Adultes s'occupe activement de concert avec l'UNESCO de renseigner les gens et se tient en relation avec les mouvements d'éducation pour adultes en Grande-Bretagne, aux Etats-Unis, dans les pays du Commonwealth, et dans les états scandinaves.

Pourquoi une infirmière doit-elle continuer d'étudier? Parce que c'est une triste époque dans la vie, lorsqu'un homme ou une femme admet qu'il est trop tard pour apprendre ou se vante qu'il n'a plus rien à apprendre ou qu'il est trop paresseux. Dans un des derniers numéros de *Better Homes and Gardens* Hal Burton disait sagement: "Mettez-vous dans la classe des fossiles si vous n'avez plus le goût de rien apprendre . . . si vous ne faites que jeter un coup d'oeil sur les journaux, n'écoutez à la radio que les programmes qui vous donnent du plaisir, rarement lisez-vous

un livre ou n'apprenez un travail nouveau."

Dans un livre intitulé "The Mature Mind" l'auteur H. A. Overstreet fait remarquer "qu'un adulte qui cesse après sa jeunesse d'apprendre et de réapprendre les faits ou de se faire un opinion nouvelle est aussi perdu de nos jours qu'un aveugle marchant dans une pièce familière où les meubles ont été déplacés."

Que peut-on retirer de ces études? En un mot, vous pouvez trouver la solution de votre problème ou les problèmes des autres peuvent vous devenir compréhensibles.

Une des caractéristiques de notre siècle est que tout homme dans sa vie a l'impression de n'être pas bien compris d'autrui et parfois il a de la difficulté à se comprendre lui-même. L'éducation des adultes, en permettant l'étude en groupe d'un problème, en permettant de parler de son problème, aide à conserver l'intégrité de la vie d'une femme.

La méthode de conférence dans l'éducation des adultes est un moyen efficace pour tenir l'esprit en éveil. Tant que les hommes auront des personnes à qui parler il y aura des échanges d'idées et des discussions. Ces séances d'éducation des adultes ne tournent pas en conversation oisive. Les gens qui y assistent sont là pour apprendre et ils partent de ces réunions plus éclairés.

Un autre avantage de ces réunions est d'aider à penser juste et à acquérir une largeur d'esprit qui donnera à ces personnes la réputation d'être bien renseignées.—*Questions and Answers*, Canadian Association for Adult Education.

Les Ecoles d'Infirmières au Milieu du Siècle

Un rapport, préparé par des éducatrices d'expérience en nursing et offert par les organisations nationales du nursing des Etats-Unis, doit être entre toutes les mains des administrateurs de nos écoles du Canada.

Ce livre présente l'état ou ce que l'on trouve aujourd'hui dans nos écoles d'infirmières. En 1948, six organisations formèrent un comité conjoint afin d'établir un programme susceptible d'améliorer les soins donnés aux malades. Le premier devoir de ce comité fut d'examiner ce qui s'enseigne en théorie et en pratique durant le cours d'une infirmière. Un sous-comité fut formé pour l'analyse du travail et le résultat montre le travail actuel des infirmières.

La situation aux Etats-Unis étant à peu près semblable à celle du Canada, ce rapport est de nature à nous rendre de grands services. — Publié par *The National Committee for Improvement of Nursing Services*, 1790 Broadway, New York City 19.

Une Analyse

Un article sur l'importance des soins au malade et le rapport existant entre la qualité de ces soins et la valeur de l'infirmière en service général a attiré notre attention. L'auteur se demande fort à propos: Pourquoi les infirmières pensent-elle que le service général est un service servile? Avons-nous tellement souligné l'importance des surveillantes jusqu'au point que l'infirmière hésite à avouer qu'elle fait encore du service général? Les administrateurs des hôpitaux n'ont-ils pas fait valoir et démontrer l'importance du service général? Offre-t'on à ces infirmières l'occasion de se développer et de progresser? Ont-elle un salaire leur assurant un sécurité financière? Des conditions de vie leur assurent une sécurité émotionnelle et sociale?—*The Modern Hospital*, Oct. 1950.

Assemblée du Comité Exécutif

Une assemblée du Comité Exécutif de l'Association des Infirmières du Canada sera tenue le 8, 9 et 10 février, 1951, dans le Viceregal Suite, de l'Hôtel Ritz-Carlton, Montréal.

M.L.I.C. Nursing Service

Olive MacPhee (Framingham Union Hospital, Mass., and McGill University public health course) has resigned from the service of the Metropolitan Life Insurance Company to become superintendent of nurses at Pt. Edward Sanatorium, N.S. Miss MacPhee served for several years as company nurse in Glace Bay, N.S.

Corneal Transplant

This procedure is indicated where corneal opacification occurs without serious involvement of other ocular structures. Replacement of the central portion of the cloudy cornea with clear tissues from another healthy cornea results in a clear space through which the patient can see. The number of suitable cases is actually very small.—C. D. Townes.

Student Nurses

Chronic Glomerulo Nephritis

ISABELLE STEPHENS

Average reading time — 5 min. 12 sec.

MR. YEE, a 34-year old, single, Chinese was admitted to the hospital on October 18. He was born in China but has lived in Canada for 23 years. He works in a café. Family history revealed that his father had died, age 63, of a stroke; his mother is age 75, alive and well. He has a brother living.

His physical examination revealed general symptoms of edema, including swollen legs and ankles. His face and neck were puffy. Mr. Yee felt a fullness in his throat, which he described as an "oyster." Well nourished and seemingly physically fit, he had had blurring of vision since his illness. His abdomen was full, soft, hot, tender to palpation. Percussion revealed free fluid. His kidneys were not palpable. The provisional diagnosis of chronic glomerulo nephritis with edema was made.

X-ray examination showed: (1) a gas-filled colon; (2) the left kidney shadow was visible but the right kidney was much less distinct.

A chest fluoroscopy showed the diaphragm to be high in position due to considerable ascites. There was a moderate amount of fluid in the left costophrenic angle but there was no definite evidence of pericardial effusion.

Routine urinalyses were done twice weekly and revealed albumin, usually 4 plus; many hyaline casts; increasing numbers of R.B.C.; epithelial cells.

The most important of these abnormal constituents are albumin, red blood cells, and casts. Normally there is no albumin present in urine but it appears when, due to disease of the glomerulo capillaries, it seeps through from the bloodstream into the glomerular capsule. Red blood cells appear when disease of the glomerulo capillaries allows cells as well as protein to osmose through. Casts, which are not normally found in urine, are due to the coagulation of albumin in the tubules of the kidney. These little plugs of albumin are forced out by the flow of blood.

Blood chemistry showed the non protein nitrogen value was increasing gradually and had gone from 28.9 to 36.6. The N.P.N. is increased in nephritis and urinary obstruction.

Sedimentation velocity was 87 mm. in 1 hour. Normal velocity is 1-10 mm. in 1 hour and it is increased in infections and inflammatory conditions.

A blood analysis was done and the white blood cell count was 10,200 per cu. mm. of blood, normal being 5,000 to 9,000. This increase was due to infection.

The basal metabolism reading was minus 26, the normal being plus 15 to minus 15.

A blood cholesterol value is normally 140-200. Mr. Yee's was 625. A high blood cholesterol and low B.M.R. signifies hypothyroidism. He was given dessicated thyroid gr. ½ daily.

All of Mr. Yee's treatment has been purely medical. The usual treatment for nephritis is: (a) restrict fluid to 1,000 cc. daily; (b) restrict sodium; (c) high protein diet of 100 gm. daily with added protein drinks.

In this treatment, by restricting fluids and salt and giving a high, pro-

Miss Stephens is a student nurse at the Victoria Hospital, London, Ont.

tein diet, we try to get rid of the edema. This edema is due simply to the retention of water and salt in the body because of diminution in the output of urine. Edema is due also to the diminution of the plasma proteins so the osmotic pressure exerted by them is not sufficient to counteract the mechanical pressure of the blood within the capillaries. Such a diminution in plasma proteins results from a loss of proteins (primarily albumin) in the urine at a more rapid rate than the liver can form them.

Rest in bed is continued until recovery is complete but the patient is allowed bathroom privileges and he is weighed twice weekly to watch any weight changes.

Mr. Yee was given thiomerin ½ cc. as a diuretic. He was receiving daletal tablets q.i.d.

The new wonder drug cortisone, which has proven a big help in rheumatoid arthritis, is being used experimentally in nephritis. Before this drug can be administered, the patient is put on a strict diet to try and make the body maintain a control. The diet is to be qualitatively and quantitatively identical each day. It is a 2,500-calorie diet with: protein, 120 grams; C.H.O., 300 grams; fat, the balance.

Nursing care is very important. The nurse must keep accurate intake and output sheets daily. This requires the cooperation of the patient who keeps a record of his intake.

The testing of the urine is important. Other observations should include the presence and character of edema and body weight. Daily bowel evacuation is necessary in order to keep the kidney load at a minimum.

Proper diet is essential. It is the nurse's responsibility to see that the patient does not get any salt and that he drinks the correct amount of fluid.

The prognosis on Mr. Yee is only fair. If he will cooperate and remain on his diet, his edema should decrease so that he would feel better. Cortisone may help but as yet it is too early to speculate. There has been a slight decrease in edema but the laboratory reports continue to show casts, albuminuria, and R.B.C. in urine.

When a patient recovers sufficiently to return home, he should recognize the need of a program of health and to assume responsibility for following it. Home instructions for patient include: Avoid colds; get at least eight hours' sleep; avoid constipation; use salt and other condiments sparingly; drink water daily; watch wrists and ankles—if swollen, report to the doctor promptly.

Book Reviews

Diet Manual of The Montreal General Hospital—compiled by the Committee on Hospital Diets. 80 pages. Obtainable from the Dietary Dept., General Hospital, Montreal 18, Que. 1950. Price $2.50.

Reviewed by Marion E. Nash, Assistant General Secretary, Canadian Nurses' Association.

A new manual, the first of its kind prepared by a Staff Committee of the Montreal General Hospital, should prove of immediate value to medical, dietetic, and nursing students. This handy little book of 80 pages presents not only a set of standard diets for use in the care of patients but also an account of the principles underlying the construction and use of these diets. The terms of reference are the dietary standards for Canada, approved by the Canadian Council on Nutrition, the Department of National Health and Welfare. While this manual is prepared specifically for use at the M.G.H., it is a book that any graduate nurse could easily tuck in her bag, finding it a helpful guide when special diets are prescribed. This manual is authoritative, concise, practical, has a place for brief notes, is indexed, and small enough to slip into a pocket—altogether a worthwhile little book.

Introduction to Microorganisms, by LaVerne Ruth Thompson, R.N. 454 pages. Published by W.B. Saunders Co., Philadelphia. Canadian agents: McAinsh & Co. Ltd., 388 Yonge St., Toronto 1. 2nd Ed. 1949. Illustrated. Price $4.75.

Reviewed by Margaret Lonergan, Science Instructor, St. Paul's School of Nursing, Vancouver.

Miss Thompson states in the preface to her book that it is written "for the student whose chief interest lies in the field of health and welfare instead of bacteriology *per se.*" Therefore, it is to be expected that emphasis is placed on those activities of microorganisms which influence man and his environment or on the public health aspect of microbiology.

The text is divided into five units. The first outlines microscopic life in general; the second deals with bacteria; the third considers parasites and their relation to man; the fourth presents the common pathogens and the infections they cause; the fifth traces organization for public health.

The first chapters are especially well adapted to the beginning student with no previous knowledge of microbiology but succeeding chapters become rapidly much more difficult. In view of this fact, specific additional studies relating to terminology and vocabulary would be required to supplement the textbook material. Therefore, as an instructor's text, it would appear to be incomplete in regard to gradual incorporation of factual matter which would prepare the student for new concepts as they appear in the book. In many introductory courses to this field, a section is devoted to a brief history of microbiology. Since the book is pointed at one aspect of microbiology—public health—this probably is the reason why such a chapter is replaced by a history of public health organization.

Excellent explanatory sections will be found pertaining to cell structure, life patterns of parasites, infection and body defences, and environmental control. The suggested laboratory procedures and experiments should prove valuable to students in offering practical experience and proof. Statistical graphs, diagrams, and photographic illustrations greatly add to the interest of the material presented. Chapter summaries, in outline form, make for easy review. Current research is mentioned and experimental evidence presented.

"Introduction to Microorganisms" would appear to be of real value to the student, especially in the light of disease control, as a review of microbiology and for laboratory experiments.

The Commonsense Psychiatry of Dr. Adolf Meyer—Fifty-two selected papers, edited, with biographical narrative, by Alfred Lief. 677 pages. Published by McGraw-Hill Co. of Canada Ltd., 50 York St., Toronto 1. 1948. Price $8.00.

Reviewed by Peggy Pike, Instructor of Nurses, Allan Memorial Institute of Psychiatry, Montreal.

Alfred Lief has attempted to give us a picture of the work done by Dr. Adolf Meyer in America. In so doing, he gives us, not only the outline of a man dedicated to a cause, but the far-flung effect of one man's efforts. Adolf Meyer did not confine his work within walls of an institution for the mentally ill but extended his interest to the family and the community. Many of the papers included in these selections are wonderful reading material for the health-minded nurse, for many of the questions she may be asked to answer are discussed in a warm, understanding manner. For example, he poses the problem faced by the mother of a retarded child and follows this with helpful suggestions for happier living for both.

The nurse will find much of interest in these selections. I feel that a copy in a nursing library would be valuable and would satisfy the needs of the average nurse.

Introduction to Psychiatric Nursing, by Marion E. Kalkman, R.N. 336 pages. Published by McGraw-Hill Co. of Canada Ltd., 50 York St., Toronto 1. 1950. Illustrated. Price $4.55.

Reviewed by Winonah Lindsay, Assistant Matron, Lancaster D.V.A. Hospital, West Saint John, N.B.

This is not a textbook in the true sense of the word, yet the wealth of informative material included forms the basis for all fields of nursing. The author states that it is a book "to stimulate interest in further study" and she has provided the means for this study—the bibliographies are both authoritative and extensive.

The content is in five parts and all contribute to the final objective—to stimulate interest in good patient care. Part One deals with the accurate observation of physiological and mental mechanisms and their

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precise recording. Before the nurse can understand the dynamics of nursing in psychiatry it is necessary to understand personality development—the subject discussed in Part Two. What can be done to help the patient and how the nurse can accomplish it forms the basis of the next two sections; and, finally, the care of various reactive types is discussed in a dynamic fashion.

Deep understanding of student needs is indicated by the manner in which subjects and authors are indexed. In the latter instance it should be noted that all references to a particular author's articles or books are listed under the writer's name. Thus the student avoids turning to the same reference again and again.

This introduction provides the answers to many of the questions that are so rarely expressed by the nurse new to the field of psychiatry. The simple, swiftly-moving style contributes to ease of reading and the numerous, authentic examples—in the section on mental mechanisms—maintain the reader's interest.

Miss Kalkman states that she has written for the newcomer to psychiatry but instructors would find the book of unquestionable value in general nursing education. However, this is not a book to be used indiscriminately, unless the students have a better than average understanding of elementary psychology and sociology.

Of particular interest are Chapters 16 and 17 on nurse-patient reactions and approach to the patient. Nevertheless, these points could have been introduced to better advantage in the early part of the book. This is especially true if the students were in the clinical situation, as is so necessary in psychiatric nursing.

The author has nonetheless made an outstanding contribution to the effort to stimulate "creative nursing." If the content were not of such high quality, the wide range of reference material included, alone, would make the "Introduction" a worthwhile addition to any nursing library.

Professional Adjustments, by Sister Mary Isidore Lennon, R.S.M., R.N., B.S., M.A., M.S. 362 pages. Published by The C.V. Mosby Co., St. Louis. Canadian agents: McAinsh & Co. Ltd., 388 Yonge St., Toronto 1. 2nd Ed. 1950. Price $4.00.

Reviewed by Nora Street, Instructor of Nurses, Grey Nuns' Hospital, Regina.

The author makes it clear in her preface that the purpose of this book is to act as a guide to student nurses in order to help them in the solution of their professional problems.

The contents are most complete in every way. The writer tends to stress spiritual values and attempts to restore some of the ideals in nursing which we, perhaps, tend to lose sight of in these modern times. Some of the material for the Catholic nurse could be looked upon as superfluous, since it is not of great value to the non-Catholic student and should be common knowledge already to the Catholic.

The outline summary, review questions, projects, and references at the end of each chapter should prove of considerable assistance in arousing interest in this course. The answers to the questions may be a little obvious but the idea is very helpful.

The author shows considerable understanding of students in her writings. Her chapter on discipline is very good, with special consideration of the student's need as an individual. There is also an excellent chapter on The Nurse's Conversation. It deals with the different phases, such as conversation with the patient, the physician, and other nurses, with attention to the fact that there is sometimes undesirable familiarity on the part of the nurse.

Of particular value to the student is the chapter which deals briefly and concisely with the conduct of meetings. Here the duties of the chairman, the secretary, and other officers of a student organization are outlined in a manner easy to assimilate.

The author presents in Legal Responsibilities of the Nurse some good material worthy of study and gives examples of cases to support each statement, with adequate yet short explanations of legal terms.

The material on the nurse's social life, personal economics, the section on night duty, and the unit on professional organizations and activities are worthy of attention.

This is a book which compares most favorably with others in professional adjustments. It has an easy flowing style and clear presentation, which makes it very readable. As a text it contains all the material necessary for a student nurse up to the time of her graduation.

Ordinary people think merely how they will *spend* their time; a man of intellect tries to *use* it.—SCHOPENHAUER

Victorian Order of Nurses

The following are staff changes in the Victorian Order of Nurses for Canada:

Appointments—Dartmouth, N.S.: *Elizabeth MacKenzie* (Highland View Hosp., Amherst, N.S.). Digby, N.S.: *Mary J. Prang* (University of Toronto) as nurse in charge. Dundas, Ont.: *Bessie Jackson* (McGill University) as nurse in charge. Gravenhurst, Ont.: *Anna Charles* (U. of T.) as nurse in charge. Halifax: *Margaret Nesbitt* (University of Western Ont.). Hamilton: *Letty Neaves* (U. of T.). Kingston: *Irene J. Langley* (U. of T.). Lachine, Que.: *Philomena Fuoco* (University of Montreal). Lincoln County: *Merle R. Smith* (Hamilton Gen. Hosp.). Montreal: *Mrs. M. Desjardins* (Hôp. Ste-Justine, Montreal); *Mrs. E. Laidlaw* (U.W.O.); *Norma Lee* (Brockville Gen. Hosp.). North Vancouver: *Alice Cannon* (Chipman Memorial Hosp., St. Stephen, N.B.). North York, Ont.: *Frances Krotz* (Victoria Hosp., London). Ottawa: *Lucille Brule* (University of Ottawa); *Bessie Buck, Jean S. McLaren* (Royal Victoria Hosp., Montreal); *Lorraine McMullen* (U. of O.); *Agatha Simister* (Ottawa Civic Hosp.); *June Woodruff* (Montreal Gen. Hosp.). Port Arthur: *Virginia Blackhurst* (U.W.O.). Sackville, N.B.: *Anna Hanusiak* (Hotel Dieu, Montreal). Saskatoon: *Shirley Newby* (Saskatoon City Hosp.). Surrey, B.C.: *Lillian Frank* (University of Man.). Toronto: *Phyllis Gallagher, Phyllis E. Jones, Vivian Walker* (U. of T.); *Irene Jackson* (U.W.O.); *Helen MacKay* (McGill U.); *Margaret Veit* (Toronto Gen. Hosp.). Trenton, Ont.: *Barbara Mason* (London Hosp., Eng.). Truro, N.S.: *Winnifred James* (U.W.O.) as nurse in charge. Victoria: *Marguerite Butters* (University of B.C.). Waterloo, Ont.: *Beatrice Tomlin* (U.W.O.). Winnipeg: *Donna Baldwin* (Grace Hosp., Winnipeg).

Transfers—*Dorothea Atkinson* from Carleton Place, Ont., as nurse in charge to Montreal; *Mary Brebner* from Gravenhurst, Ont., as nurse in charge to Edmonton; *Eleanor Crawforth* from London to Windsor, Ont.; *Mary (Elias) Fenwick* from Calgary to Edmonton; *Catharine Gannon* from Trail, B.C., to Vancouver; *Audrey Price* from Burnaby, B.C., to Victoria; *Eva Secord* from Lincoln County, Ont., to St. Catharines as nurse in charge; *Irene Sheasby* from Brantford to Calgary; *Sybil Steele* from Toronto to

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Collingwood, Ont., as nurse in charge; *Lorna Warman* from St. Catharines as nurse in charge to Hamilton; *Marion Werry* from Chatham, N.B., as nurse in charge to Chatham, Ont., as nurse in charge; *Eileen Woodbyrne* from Timmins, Ont., to York Township, Ont.

Resignations—Chatham, Ont.: *Julia Meyer* as nurse in charge. Collingwood, Ont.: *Elizabeth Berryhill* as nurse in charge. Edmonton: *Dorothy Bateman*. Fort William: *Dorothea Cross*. Kingston: *Betty Murray*. London: *Margaret Bridge*. Montreal: *Mrs. A. Ashley, J. Longseed, M. Stacey*. Niagara Falls: *Jean Erion*. North Vancouver: *Alice Johnson*. Ottawa: *Patricia Allen, Marjorie Green, Hilda Willis*. Owen Sound: *Lyla Groat*. Sackville: *Margaret Nicholson* as nurse in charge. Sarnia: *Deby Hooper*. Sudbury: *Madelon Gough*. Timmins: *Eileen Soucie*. Toronto: *Sybil Bergenstein, Elizabeth Davidson, Eileen Goodwin, Elizabeth Peppler, E. Stewart, Helen Storer, Betty Topper, Grace Trott, Elizabeth Westcott*. Vancouver: *Lavinia Crane*.

Scholarship Awards—The following nurses were awarded Victorian Order scholarships and are attending the universities indicated for the 1950-51 term:

UNIVERSITY OF ALBERTA: *Beulah Rose, Jean Sawdon* (U. of A. School of Nursing).

UNIVERSITY OF BRITISH COLUMBIA: *Phoebe Clement* (Presidency Gen. Hosp., Calcutta, India); *Joyce E. Webster* (Winnipeg Gen. Hosp.); *Vivian Wylie* (Royal Jubilee Hosp., Victoria).

DALHOUSIE UNIVERSITY: *Anna Adams* (All Saints' Hosp., Springhill, N.S.); *Frances Cook* (Ottawa Civic Hosp.); *Dorothy Loane* (Royal Victoria Hosp., Montreal).

UNIVERSITY OF MANITOBA: *Frances McKenzie* (Royal Jubilee Hosp., Victoria).

MCGILL UNIVERSITY: *Ada McEwen* (Montreal Gen. Hosp.); *Dorothy Mizuhara* (Vancouver Gen. Hosp.).

MCMASTER UNIVERSITY: *Betty Minke, Helen Nelles* (McM. U. School of Nursing).

UNIVERSITY OF MONTREAL: *Jeannette* and *Noella Bellemare* (Hôp. St-Joseph, Three Rivers); *Germaine D'Allaire* (Hôp. Ste-Justine, Montreal); *Therese Farmer, Cecile Vincent* (Notre Dame Hosp., Montreal); *Annette* and *Jacqueline Gregoire* (Hôp. St-Sacrement, Quebec); *Yolande Paradis* (Hôp. St. Michel Archange, Quebec).

QUEEN'S UNIVERSITY: *Margaret Donevan, Jean Lloyd* (Kingston Gen. Hosp.); *Edna Haussler* (St. Michael's Hosp., Toronto).

UNIVERSITY OF TORONTO: *Helen Brunkard, Agnes Buckingham* (Kitchener-Waterloo Hosp.); *Eileen Carson, Helen Minaker, Edythe Young* (Oshawa Gen. Hosp.); *Jean Cummine, Anne Jones, Joy Walling, Jessie Yule* (Toronto Gen. Hosp.); *Betty Foster, Lois Leeson* (Victoria Hosp., London); *Lorraine Somerville* (Ottawa Civic Hosp.); *Margery Spencer* (Port Arthur Gen. Hosp.); *Anne Wylie* (Wellesley Hosp., Toronto).

UNIVERSITY OF WESTERN ONTARIO: *Doris Arrand, Norma Heatly, Dorothy Lounsbrough, Edna May Stoddart, Ruth Walker* (Victoria Hosp., London); *Amy Eacott* (Hosp. for Sick Children, Toronto); *Dorothy Nicol* (Hamilton Gen. Hosp.).

The following are attending the institutions indicated on advanced scholarships:

MATERNITY CENTRE, NEW YORK: *Bernice Gordon*. MCGILL UNIVERSITY: *Elizabeth Riddell* (Royal Columbian Hosp., New Westminster). UNIVERSITY OF TORONTO: *Ruby Good* (Hamilton Gen. Hosp.).

Appointments—Calgary: *Marguerite Rose* (Holy Cross Hosp., Calgary). Edmonton: *Mrs. Thelma Irvine* (University of Alta.). Fort William: *Mrs. Ruth Drysdale* (University of Man.). Halifax: *Gladys MacLennan* (Montreal Gen. Hosp.). Kirkland Lake, Ont.: *Alice MacDonald*. London, Ont.: *Mrs. Ruby Bond* (University of Western Ont.). Moncton: *Helen LaFitte* (Hotel Dieu, Moncton). Montreal: *Lorraine McGregor* (Royal Victoria Hosp., Montreal) and *Susan Pike* (Alfred University, N.Y.). Sarnia, Ont.: *Mrs. Annie Ure* (Port Arthur Gen. Hosp., Ont.). Sudbury, Ont.: *Maude Rhodes* (Dudley Rd. Hosp., Birmingham, Eng.) and *Josephine Rowlett* (Montreal Gen. Hosp.). Toronto: *Akke Yntema* (District Nursing School, Holland). Vancouver: *Mary Hopkins* (University of Toronto). Winnipeg: *Elly Enns, Mary Guenther* (St. Boniface Hosp., Man.), and *Dorothy Whitworth* (Winnipeg Gen. Hosp.).

Re-admissions—Toronto: *Mrs. Hope Kuglin, Eileen Pocock*. Windsor, N.S.: *Jean Adams*.

Transfers—*Patricia Corbett* from Montreal to Lake of Two Mountains, Que., as nurse in charge; *Kathleen Fultz* from Halifax to Montreal; *Jessie MacCarthy* from Vancouver to Montreal.

Leaves of Absence—Calgary: *Helen Irving* as nurse in charge. Toronto: *Eileen*

Carson, Ruby Good, Marion Orr, Bernice Seeds, Norma Steeves, Katharine Tuttle, Joy Walling.

Resignations—Dartmouth, N.S.: *Irene Andrews.* Edmonton: *Mrs. Doris Curial* as nurse in charge. Hamilton: *Annette Allison.* Montreal; *Jean M. Ellis, Anna Knecht, Marjorie Shaw, M. L. Shepherd, Margaret Simmers, Evelyn Weaver.* Peterborough, Ont.: *Wilma Armstrong.* Toronto: *Mrs. G. Moores, Helen Storer.* Truro, N.S.: *Nettie Bailey.* Vancouver: *Elizabeth Hayden.* Winnipeg: *Louise Fast.*

News Notes

ALBERTA

LAMONT

Mrs. A. Cowan of Edmonton was elected president of the Archer Memorial Hospital Alumnae Association at the recent annual meeting held in Edmonton. Dr. J. M. Lees was guest speaker at the dinner when his topic was "Atom Bomb and Civil Defence Against It." The guests found his theme both interesting and timely. The speaker was thanked by Mrs. C. E. F. Wolff. Dr. M. A. R. Young, superintendent of the hospital, spoke briefly and Vera Alho, retiring president, introduced Mrs. Cowan. Soloists included Mary Lou Soper and Earl Joundre. June Misku was accompanist. Those present included the nursing faculty of the hospital, medical and dental faculties and their wives, the professional staff of the Provincial Health Clinic stationed in the hospital, graduates of the school, and honorary members.

In addition to the president, other officers include: Vice-presidents, Mmes Wolff, L. Langford; secretary-treasurer, Mrs. B. I. Love; news editor, Mrs. A. Lett; executive, Mmes J. D. Soper, E. Bryks, J. Miller, Miss P. Ritz. The honorary president is L. Marie Young, superintendent of nurses.

PONOKA

Twenty-one members were present at a meeting of District 2 when it was decided to donate $50 to the Sunshine Club of Ponoka. E. Kemp moved a vote of thanks to Valerie Wheeler for her untiring efforts in the A.A.R.N. and the community and wished her good luck in her new field of nursing at New Brigden.

BRITISH COLUMBIA

VANCOUVER ISLAND DISTRICT

About 92 nurses of the five chapters of the district were welcomed to the November

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1950 INDEX

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meeting by Mrs. R. Brown, first vice-president of Victoria Chapter. In the absence of Sr. M. Claire, of Campbell River, K. Bailey, of Port Alberni, presided. Dr. R. D. G. McNeeley, chief pathologist, Royal Jubilee Hospital, Victoria, spoke to the nurses on "Cortisone and ACTH." Using slides and graphs, he outlined the history of research on these substances, dating back to 1856 when Dr. Thomas Addison first described the symptoms of a disease since named after him.

CANADIAN RED CROSS SOCIETY

has recently provided for **two Annual Bursaries** to be made available to Red Cross Staff Nurses for post-graduate preparation. The bursary is to cover tuition, a monthly stipend, and other miscellaneous costs.

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Application forms and further information may be had by applying to:

National Director, Nursing Services, The Canadian Red Cross Society, 95 Wellesley St., Toronto 5, Ontario.

Janie Jamieson, second vice-president, R.N.A.B.C., and surgical supervisor, Royal Jubilee Hospital, was welcomed as a new member to the district. The resignation of Mrs. D. B. Quayle, Ladysmith, as *Canadian Nurse* representative, was accepted with regret. C. Harrington, instructor of nurses, St. Joseph's Hospital, was chosen chairman of the Nominations Committee, assisted by Miss Bailey and D. Priestly of Nanaimo. The next district meeting is scheduled for May 4 at Nanaimo.

CHILLIWACK

Mrs. J. Edmeston was in the chair at a recent meeting of Chilliwack Chapter. The chapter by-laws and constitution revision were discussed at this well-attended gathering. One amendment was made and the amended revision carried. A sum of money was voted to the Christmas Fund for parcels to be sent to the soldiers of the Canadian division in Korea. Mrs. F. Storey reported on the convention of the B.C. Council of Women and she brought before the members a number of resolutions for the chapter's support in the work of the Council. Most of these were tabled, after discussion, for further information before the vote could be taken.

The Financial Convener's report revealed that satisfactory returns had been received from the rummage sale. Plans for the Christmas party centred around the idea of a children's party, members to bring gifts of a toy or food for the local Community Chest. Mrs. F. Barwell convened the nurses' party with Mary Brown in charge of refreshments.

Mr. Harold Clarke showed slides of his trip through the Scandinavian countries, England, Scotland, and northern Europe. He has recently returned from accompanying a party of forest industry representatives on this tour.

CLOVERDALE

The South Fraser Chapter held its annual meeting when it was announced that Dorothy Rogan, White Rock, is to receive the first bursary presented by the chapter. Olive Clancy was reappointed chairman of the Dance Committee and plans are being made for the second annual nurses' dance. The guest speaker was Mrs. Helen Condie, executive secretary of the B.C. Spastic Paralysis Society, whose informative talk on the organization and function of that association was much enjoyed by the members. A discussion period followed and coffee was served later by Mrs. Heppell.

The members of the executive include: President, Mrs. P. Payton; vice-presidents, I. Leonard, J. Coupal; secretary-treasurer, J. Pallister. Committees: Membership and finance, Mrs. J. Keays; social and program, Mrs. A. Heppell. The press reporter is Mrs. H. Rainsforth.

COMOX

Mr. R. W. Woolsey, representative of Abbott Laboratories Ltd., Montreal, addressed the members of Plateau Chapter recently at St. Joseph's Hospital. Twenty-five nurses heard Mr. Woolsey's lecture on the latest techniques in the administration of intravenous solution and blood transfusions. He demonstrated the newest equipment and showed a color film made in a Philadelphia hospital, revealing the most modern and efficient methods of collecting, storing, and infusing blood, and for the conversion of blood to plasma. Dr. H. A. L. Mooney thanked the speaker for his interesting and informative talk.

Mrs. T. Tams, secretary, reported on the district association meeting. She also commented on the successful whist sponsored by the chapter.

CRANBROOK

The experiment in combining staff education with the evening meetings of Cranbrook Chapter has proven very successful. Attendance has increased and the non-practising nurses are able to keep in step. A recent guest speaker was Mr. Geo. McDonald, pharmacist, who was able to give answers to many puzzling questions.

New additions to the hospital staff include Mrs. V. Bain from Scotland and Mrs. D. Strilchuk, a St. Eugene graduate, who has returned to duty.

KAMLOOPS-TRANQUILLE

Mrs. H. Hopgood and Fern Primeau, two staunch supporters and workers for the Chapter, were recently honored with presentations. Mrs. Hopgood, chapter president, will make her home in Vancouver. Miss Primeau has been transferred to Vancouver and will do public health work there.

A sale of used clothing realized the sum of $212. In charge of the sale were Mmes

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Hopgood, A. Galloway, and C. Dalgleish. The money will pay for special nurses for patients unable to meet the cost. The fund will be administered by a committee, consisting of the hospital matron, president and treasurer of the chapter. H. MacKay, superintendent of nurses, Royal Inland Hospital, Kamloops, rounded out the meeting with her account of a recent hospital convention.

KELOWNA

At a meeting of Kelowna Chapter, Mrs. M. Rolph, district councillor, presented her report. It was interesting to learn that there are now over 300 registered nurses in the Kamloops-Okanagan District. Mrs. Rolph, S. Blackie, and M. Davies were appointed as the Nominations Committee for the election of officers. Resolutions from the B.C. Council of Women were discussed and voted upon. Dr. George Athans presented an instructive talk on "Cortisone" and the nursing problems associated with the use of this drug. Dr. Athans is on the medical committee governing its use at the Kelowna Hospital. New chapter members include N. Hill, R. Pollard, P. Pollard, and B. Dexter.

Mrs. J. Chambers was convener for the Christmas Shopping Tea when "home-cooking" tables were an added feature. At the Christmas Party members brought toys and books for the children's ward of the hospital. J. Brodie was in charge of entertainment.

VANCOUVER

St. Paul's Hospital

A new wing to the hospital has been completed. The steps and the front entrance on Burrard have been removed and the structure, three storeys high, has been extended out to the street. A curved driveway leads off Burrard to the entrance. The new wing houses the administration offices, cashier's office, payroll office, etc. The admitting office on the left of the new entrance has special private cubicles. The Medical Library, under the supervision of Miss Flahiff, and the Medical Social Service have spacious new accommodations. The doctors have acquired a beautiful new lounge, also a new call system—"the Doctors' Register." They are now able to check in and out of the hospital at three different points. The third floor has 20 additional beds and on this floor are piped in oxygen and suction lines. The Sisters have a new Community Room on the second floor. Sr. Superior's office has also been set up here. Plans are being made for the establishment of an Arthritic Clinic and an Out-Patient Department. The orthopedic patients on the fourth floor also enjoy a new sun-deck.

The fortunate 184 alumnae members who attended the "homecoming" in the nurses' home in October know what fun it was and also what a feat of organization and industry was accomplished by Mrs. Dawe and her committee. A hot turkey dinner with all the necessary little niceties was served. It was,

as many members were heard to remark, "Just like home cookin'." Mrs. Murray presided in her irresistible "grand manner." Sr. Columkille renewed acquaintances and welcomed "all my girls back home." "I may not know your married name and I may have forgotten your maiden name but I know you all," quoth she and this is so true as witnessed by her warmth and tenderness for all. Mrs. Fitzjames, as representative of the oldest class (1912), gave a short address. L. Jacobs (1950), as the representative of the youngest class, replied. Sr. Columkille was then presented with a bouquet of 'mums. Special guests of the evening were Sr. Superior, Sr. Thérèse Amable of Cranbrook, and Sr. M. Gellina of New Westminster.

Special thanks for this successful affair go to Mrs. Dawe and her committee, Sr. Louise Marie from the main kitchen, Mrs. Barnes, and M. Brown who designed the novel little scroll-like menus. Mrs. MacKenzie donated flowers for all tables and an exquisite orchid centrepiece for the head table.

Mother Catharine de Bologne, a St. Paul's graduate and former Superior, has been elected a member of the American College of Hospital Administrators. Candidates are selected for this honor by qualifying through successful experience as administrator, outstanding service in the field of nursing, and by meeting the professional standards of the college. Mother Catharine was present to receive the honor at the convocation ceremony.

Sr. Thérèse Amable has been appointed superior of St. Eugene's Hospital, Cranbrook. Sr. Anne, formerly in charge of pediatrics at St. Paul's, is resuming her studies at Seattle University. Sr. Florence Mary has been elected treasurer of the B.C. Hospital Administration. B. Facchin is now public health nurse at Burns Lake. L. Olivier is back at St. Paul's after a stay in California. Mrs. E. P. (Doherty) Mulhern has returned from a trip to Rome. Betty (Green) McKenzie is now in the eastern U.S. where her husband is continuing his studies.

MANITOBA

BRANDON

Reports from the various committees were received at a meeting of the Association of Graduate Nurses. The married nurses' section reported on their very successful tea, a portion of the proceeds to be donated to the Scholarship Fund. A donation was recommended for the renewal of mattresses in the nurses' residence. Following business, D. Lewis' group took charge. Piano duet selections were contributed by E. McKenzie and M. Hagen while E. Curtis and L. Patterson presented a skit on Florence Nightingale.

ST. BONIFACE

The response to the first issue of *Estotes Fideles*, the newsletter from the St. Boniface Hospital Alumnae Association, was so satisfactory that another edition is promised early this year. Paid-up membership reached a new peak with letters from as far away as the

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Island of Cyprus, in the southeast corner of the Mediterranean. Thanks is extended to all S.B.H. graduates and they are asked to watch for the next edition.

Winnipeg General Hospital

At a recent meeting of the alumnae association the immediate past president, Mary Shepherd, told of her contacts with alumnae members in distant cities during the past few months. In Los Angeles she was entertained at a tea with 26 members present. She attended a successful fashion show and tea in Vancouver, the proceeds of which were in aid of the Alumnae Scholarship Fund. The models included some of the W.G.H. graduates. Lorraine Miller, president of the Vancouver branch, was the gracious hostess.

In the near future, afternoon meetings will be started for married graduates. These get-togethers will combine work projects and a social time under the guidance of B. Pullen.

The alumnae has sent the usual $75 donation to the Zenna Mission. A contribution is also being made to the newly established post-graduate course in obstetrics in the new Maternity Pavilion.

A group of three motion pictures provided timely information and entertainment for the members at a regular meeting. These included a travelogue on Sweden, the Eastern Ballet Festival, and the Leslie Bell Singers. A later meeting is to feature a demonstration and display of weaving, needle-lace, leatherwork, and smocking by a member of the Canadian Handicraft Guild.

D. Hibbert replaces Mrs. McFetridge on the Scholarship Committee, the latter now living in British Columbia.

NEW BRUNSWICK

Saint John

What the provincial association has meant to the nursing profession in this province was set forth by its president, Muriel Hunter, director of public health nursing service for New Brunswick, when she was guest speaker at a recent meeting of Saint John Chapter. Miss Hunter asked the 61 nurses present to be informed on what the association had done and still could do for them. She stated that grants for nursing education and legislation for the protection of nurses had come through association action.

The president, B. Selfridge, was in the chair. A report was received of the chapter's affiliation with the Local Council of Women. Ten dollars was voted as a donation to the Children's Aid shelter shower.

General Hospital

The alumnae association held a successful rummage sale, realizing the sum of $50.

The alumnae executive held a tea in honor of Jane Stephenson, newly-appointed director of nurses. A S.J.G.H. graduate, she has done post-graduate work at the McGill School for Graduate Nurses. Previous to her present appointment, Miss Stephenson was on the staff as supervisor of the maternity division.

Lancaster Hospital

Miss Price, president, was in the chair at a meeting of the Lancaster Nurses' Association when plans were made for the annual "pound" party with C. Kreutz as convener. Twelve boxes of food have been sent to retired nurses in England.

The association was hostess to the Saint John Chapter when around 90 nurses were present. Refreshments were served in the nurses' lounge with W. Lindsay and E. Mooney presiding over the coffee cups.

St. Joseph's Hospital

Presiding at a meeting of the alumnae association was Mrs. J. Ross when plans were discussed for a bridge party, under the convenership of M. Morey. A letter of thanks from an adopted English family was read, in appreciation of food and clothing parcels received. A "Book Shower" will be held in an effort to enlarge the student nurses' library. An interesting report was given by F. Wallace on the provincial association convention held in Moncton. Refreshments were served under the convenership of M. Parsons and W. Ruland.

ONTARIO

DISTRICT 1

ST. THOMAS

The Ontario Hospital was the scene of the fall meeting of District 1. The Executive met prior to the registration of 119 members attending the general meeting. Invocation was led by the Rev. J. R. Thompson of Trinity Anglican Church and Dr. J. S. Stewart, hospital superintendent, gave the address of welcome.

The theme of the afternoon session was "Nurses' Education" and the first topic—"The Preliminary Student Nurse"—was presented by Miss Hazelwood, Miss Erskine, and Miss Burston of the Nursing Office staff of Victoria Hospital, London. This included the pre-entrance visit and orientation of the student nurse. Miss MacVicor, from Victoria Hospital, and a recent graduate, gave her impressions of what a student nurse hopes to find in her hospital training. The second topic—"The Affiliating Student Nurse in a Psychiatric Hospital"—was presented by M. Cammack, instructor at the Ontario Hospital.

In the evening a turkey dinner was served by the hospital staff, when about 140 members attended. Rahno M. Beamish, R.N.A.O. president, gave an interesting and humorous address on the highlights of the C.N.A. biennial convention held in Vancouver.

DISTRICTS 2 AND 3

LISTOWEL

Hazel F. Naudett, a graduate of the Ottawa Civic Hospital, has been appointed superintendent of the Memorial Hospital. Miss Naudett, formerly with the Memorial Hospital at Carman, Man., succeeds Mabel

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Wray who had been superintendent for four years. Prior to this she had served at the Louise Marshall Hospital, Mount Forest, Ont.

District 4

Hamilton

Geriatrics was the topic at a meeting of the district held at St. Peter's Infirmary. While the members were assembling a colored film, depicting the activities and picturesque environs of the Infirmary, was shown by the superintendent, Merle Watson. During the short business meeting, Helene Snedden, chairman, thanked the members for the contributions for Christmas boxes to be sent to eleven British nurses.

Edna Freeman introduced the guest speaker —Jessie Wallace, supervisor, Toronto branch, V.O.N. In her address, "Longer Twilight—To What Purpose?", Miss Wallace stressed the need for action to meet the basic economic, social, and emotional need of the aged persons. Some communities, cited as examples, have made progress in providing housing, hospital facilities, medical and nursing care, recreation and occupation suitable to the needs of the elder citizens. These successful plans might well be adopted in other centres.

St. Catharines

At a meeting of the Educational Committee of the Community Nursing Registry interesting and informative films—"Men of Medicine," "Journey into Medicine," and "Your Life Work—Nursing"—were shown by A. Stechyshyn, radiographer at the General Hospital. Mr. Stechyshyn also reminded those present, in a short talk on "The Difficulties of X-Ray," that the problems in diagnosing are not solved as easily as is believed. E. Coffman chaired the meeting.

The Mack Training School Alumnae Association of the General Hospital held a very successful auction sale following a recent business meeting. Miss Bowman, who is in Korea, will be remembered during the holiday season. Alumnae meetings are held the first Wednesday of each month.

The following members are on the executive: Honorary president, E. Bell Rogers; president, E. Purton; vice-president, L. Kottmeier; secretary, J. Maclean; treasurer, N. Rolls; social convener, J. Turner; program convener, J. MacKay; representative to *The Canadian Nurse*, S. Murray.

District 5

The annual meeting of the district will be held in the Ontario College of Education, Toronto, on February 7 at 7:45 p.m. The guest speaker will be Dr. McKinnon Phillips, Minister of Health for Ontario.

Toronto General Hospital

Z. Creedon has been appointed assistant director, Nursing Division, Ontario Society for Crippled Children. B. Wills is now on the

staff of the Ontario Division of the Junior Red Cross and is in charge of the crippled children's work. F. King is associate professor of nursing education at the University of Western Ontario. E. Forgie is superintendent of Hillcrest Convalescent Hospital. K. Meek resigned from T.G.H. and is at "Brookhills," Port Stanley.

QUEBEC

MONTREAL

Royal Victoria Hospital

L. Ellis and G. Johnston have joined the teaching staff. Mmes McKeown and MacLean are clinical supervisors in the main building. L. Boyd is nurse in charge on Ward G, assisted by K. Ardill on Ward H. J. Barber replaced H. Sargent as head nurse on Ross 5, the latter resigning to be married. D. Watson, P. Thompson, and P. Bourns are assistant head nurses on Wards B, D, and J respectively. Jane (Brault) Bert and Thelma (McKenzie) McDonald were visitors to the school of nursing. Muriel (Peake) Spencer has moved to Vancouver.

QUEBEC CITY

Jeffery Hale's Hospital

At a meeting of the alumnae association reports were read by the nurses who had attended the C.N.A. convention in Vancouver. Mrs. Green gave an interesting talk about her trip to and from the coast. Mrs. Firth has resigned her position in the outdoor department and is replaced by Mrs. Davidson. R. Coull has been appointed charge nurse of the men's medical and surgical wards and G. Ward of the semi-private ward.

SASKATCHEWAN

Thirty nurses from schools of nursing, the Saskatchewan Department of Public Health, the Saskatoon City Department of Public Health, and the School for Nurses' Aides registered at a three-day institute in "Remedial English" held at St. Paul's Hospital, Saskatoon. This institute was under the auspices of the S.R.N.A., the director being Florence Bennee of the Nutana Collegiate, Saskatoon. Miss Bennee said, "All those teaching subject matter are teaching English as well. It is necessary to know both where a student's trouble lies and how to remedy it." Nurses who attended were trying to learn something of these two essentials.

NORTH BATTLEFORD

Lorena McColl, who was a public health nurse in this area from 1940-47, has been appointed senior public health nurse, succeeding Louise Miner, who is on organization work in connection with the proposed Prince Albert health region. A graduate of Moose Jaw General Hospital, Miss McColl has taken the public health nursing course at the University of British Columbia. When the Swift Current health region was established, she became the senior public health nurse there and remained for three years.

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REGINA

General Hospital

The alumnae association held the annual tea and bazaar in the nurses' residence when the beautiful silver tea service, presented to the residence by the alumnae, added greatly to the attractiveness of the table. Recent topics on our staff education program have been "Arthritis" and "Plastic Surgery." These are of particular interest since the hospital is one of the centres in the province for the active treatment of arthritis and for the first time a plastic surgeon is on the hospital staff.

M. Thomas and N. Davies are taking a post-graduate course in obstetrics in Jersey City.

Grey Nuns' Hospital

A successful reunion of the alumnae association was held last fall on the occasion of the 25th anniversary of the foundation of that organization. The two-day program included visits to additions made to the hospital and residence in recent years; a banquet at which the guest speakers were Matilda Diederichs, a former instructor at the school of nursing, and Lola Wilson, S.R.N.A. registrar; an afternoon tea held at Hotel Saskatchewan.

The senior class of the school entertained the September, 1950, graduates at afternoon tea following the completion of the November Nurse Registration exams.

Visitors to the hospital and school included Hazel Keeler, director, University of Saskatchewan School of Nursing, and Ruby Tinkiss of the Division of Child and Maternal Hygiene, Ottawa, who visited the maternity and pediatric departments. Sr. M. Farley, hospital superior, has been made a member of the American Association of Hospital Administrators. E. Jefferson represented the school of nursing at an institute in "Remedial English," sponsored by the S.R.N.A.

SASKATOON

City Hospital

Marjorie Goettler, formerly of the cancer clinic, was a visitor in the city from Texas.

St. Paul's Hospital

The 1950 graduates were welcomed to tea at the residence in November and a reunion was planned for the future. The annual "Kiddies' Carnival," convened by Helen Casey and sponsored by the Sodality, was the usual "howling" success! E. Lang convened an Apron Tea, sponsored by the second-year students. The nurses had an opportunity of hearing a talk on safety measures in the care of handling oxygen. A welcome back to the province is extended to A. Jasieniuk, who has been taking a post-graduate course in obstetrics at the Margaret Hague Hospital.

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Nurses for Surgical & Medical Floors (with special training). Gross salary: $180 per mo. **General Duty Nurses.** Gross salary: $175 per mo. Apply Sister Superior, General Hospital, Sudbury, Ont.

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General Duty Nurses—Medical, Surgical, Pediatrics, Maternity, Psychiatry, Tuberculosis. Beginning salary: $231. $10 differential Pediatrics, Psychiatry, Tuberculosis—evening & night shifts. 600-bed hospital with school. 40-hr. wk. 8 paid holidays. 3 wks. vacation. Laundry. Accumulative sick leave. Apply Director, Nursing Service, General Hospital, Fresno, California.

General Duty Nurses for modern well-equipped hospital. Starting salary: $120 plus maintenance. Increase at end of 6 mos. & annually thereafter for 2 yrs. Accumulative sick time. Medical & hospital plans available. 30 days holiday after 1 yr. service. 8-hr. day, 6-day wk. Travelling expenses refunded from any point in Ontario after 6 mos. duty. Apply Supt., Kirkland & District Hospital, Kirkland Lake, Ont.

General Duty Nurses. Salary: $170 plus yearly increments. 8-hr. day, 44-hr. wk. Apply, giving age, Matron, Nanaimo Hospital, Nanaimo, B.C.

Graduate Nurses for General Duty (2). Gross salary: $180 per mo. **Laboratory Technician.** 35-bed hospital. White population. 4 wks. annual vacation. 10 statutory holidays. 44-hr. wk. Residence. Transportation up to $45. Annual increments. Apply Sister Superior, Providence Hospital, Fort St. John, B.C.

Graduate Floor Duty Nurses for Mt. Hamilton Maternity Hospital, Hamilton, Ont. Large, well-equipped modern hospital (5,137 births in 1949) with opportunities for wide experience in Obstetrical Nursing. Vacancies on Delivery Floor, Nurseries, Postpartum Floors. 44-hr. wk. Statutory holidays. Bi-weekly salaries: $76-88. For other perquisites & further information write Supt.

Instructor (qualified) for Training School for Nurses, **General Duty Graduate Nurses & Dietitian** for modern 100-bed hospital in Central Manitoba town of 6,000 pop. 8-hr. duty. 1 mo. vacation after 1 yr. employment. Blue Cross Plan available. Good salary with full maintenance. Apply, stating qualifications, experience & salary expected, Supt., General Hospital, Dauphin, Man.

Graduate General Duty Nurses for 50-bed General Hospital two blocks from sea & situated in delightful, renowned playground on Island Highway. Easy access to Vancouver & Victoria. Comfortable residence. References imperative. Basic salaries: $175 & $185 if one or more years' experience. Apply, stating age & experience, Lourdes Hospital, Campbell River, B.C.

WANTED
NURSES AND DIETITIANS

Supervisors, O.R. Supervisors, Graduate Nurses & Dietitians are required for new 270-bed Sanatorium situated on the beautiful West Coast of Newfoundland. Full maintenance in lovely new Nurses' Home, uniforms & laundry provided. 44-hr. working week with 8-hr. duty. Annual 4 wks. vacation, statutory holidays & paid sick leave allowed. Active treatment & thoracic surgery carried on as well as an Out-Patient Clinic. Recreational facilities excellent—skiing, curling, skating, badminton, bowling, golf, fishing, swimming & tennis available. Apply, stating salary expected & date available for duty, to ***Supt. of Nurses, West Coast Sanatorium, Corner Brook, Newfoundland.***

British Columbia Civil Service requires: ***Registered Nurses for General Staff Duty for the Division of Tuberculosis Control***—*Vancouver Unit:* 225-bed T.B. Hospital, located at 2647 Willow St., Vancouver. All major services & student affiliation course. Registration in B.C. required. Gross salary: $182 per mo. Annual increments of $60 (over 5-yr. period). No residence accommodation. *Tranquille Unit:* 350-bed T.B. hospital, located 12 miles from Kamloops in southern interior. All major services except student affiliation. Gross salary: $188.50 per mo. Annual increments of $60 (over 5-yr. period). New modern residence; attractive bed-sitting rooms. Recreational facilities. Maintenance deduction: Room $5.00; laundry $2.50. Excellent food at 20 cts. per meal. ***Conditions—Both Units:*** 8-hr. day, 5½-day wk. rotating shifts. 4 wks. annual vacation with pay plus 11 statutory holidays. Sick leave, 20 days per yr. (14 cumulative). Promotional opportunities. Superannuation. Write for information & applications to Supt. of Nurses in respective Units or to Director of Nursing, Division of T.B. Control, 2647 Willow St., Vancouver, B.C.

Dietitian for 100-bed hospital. Salary depends on experience & qualifications. For particulars apply Supt., Soldiers' Memorial Hospital, Campbellton, N.B.

Graduate Nurses for completely modern West Coast hospital. Commencing salary: $185 per mo. less $40 for board, residence, laundry. Special bonus of $10 per mo. for night duty. $10 annual increment. 44-hr. wk. 1 mo. vacation with full salary after 1 yr. service. 1½ days sick leave per mo. accumulative to 36 days. Transportation allowance not exceeding $60 refunded after 1st yr. Apply, stating experience, Miss E. Clement, Supt. of Nurses, General Hospital, Prince Rupert, B.C.

Graduates with Operating-Room experience for duty in modern, well-equipped Operating-Room Dept. Gross salary: $38-44 per wk. Opportunities for advancement to Staff positions for qualified graduates. Apply C. E. Brewster, Supt. of Nurses, General Hospital, Hamilton, Ont.

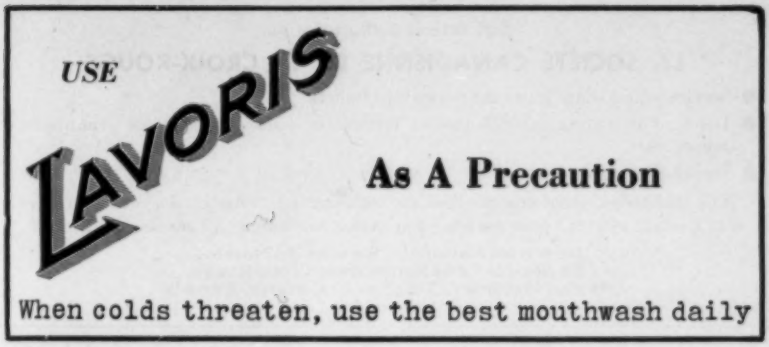
Graduate Floor Duty Nurses for General Hospital, Hamilton, Ont. Gross salary: $38-44 per wk. 88-hr. fortnight. Hospitalization & medical benefits if ill. Apply C. E. Brewster, Supt. of Nurses.

Nursing Arts Instructor, Asst. Medical Supervisor & General Duty Nurses for 200-bed General Hospital. Salary: $195 & $175 plus Cost of Living Bonus respectively. 8-hr. day. 88-hr. fortnight. 4 wks. vacation annually plus statutory holidays. Sick time. Apply Supt. of Nurses, Royal Inland Hospital, Kamloops, B.C.

Graduate Dietitian at Ontario Hospitals in Kingston, Whitby. Initial salary: $2,140 per annum plus $180 Cost of Living Bonus, less perquisites ($26.50 for room, board, laundry). Annual increment, accumulative sick leave, superannuation, 3 wks. vacation, statutory holidays & special holidays with pay. 8-hr. day, 6-day wk. Apply Supt. at above hospitals.

Registered Nurses for General Staff at Ontario Hospitals in Brockville, Hamilton, London, New Toronto, Orillia, St. Thomas, Toronto, Whitby, Woodstock. Initial salary: $1,840 per annum plus $180 Cost of Living Bonus, less perquisites ($26.50 for room, board, laundry). Annual increment, accumulative sick leave, superannuation, 3 wks. vacation, statutory holidays & special holidays with pay. 8-hr. day, 6-day wk. Apply Supt. of Nurses at above hospitals.

Vancouver General Hospital requires: (1) **Pediatric Clinical Instructor**—Salary: $207-232; (2) **Clinical Instructor** (to include Gynecological Nursing)—Salary: $207-232; (3) **General Staff Nurses**—Salary: $177-207. Perquisites: 44-hr. wk; 11 statutory holidays; 28 days vacation; 1½ days per mo. cumulative sick leave; pension plan (if under age 35). Apply Director of Nursing, General Hospital, Vancouver, B.C.



General Duty Nurses for modern, well-equipped hospital in picturesque Lakehead. 48-hr. wk. Cumulative sick leave. 1 mo. vacation after 1 yr. service. Gross salary per mo.: $185 less $20 for meals. A further $25 charged if living in residence. Annual increment. Railway fare up to $50 with 1 yr. contract. Apply Director of Nursing, General Hospital, Port Arthur, Ont.

Registered Nurses for General Staff Duty on Rotation Service. Apply, Director, Shriners' Hospital for Crippled Children, 1529 Cedar Ave., Montreal 25, Que.

General Duty Nurses for 400-bed hospital. New Wing just opened. 8-hr. day, 44-hr. wk 10 statutory holidays. B.C. registration required. Salary: $175 basic. Credit for past experience Annual increments. Vacation: 28 days after 1 yr. Sick leave: 1½ days per mo. cumulative Apply Director of Nursing, Royal Columbian Hospital, New Westminster, B.C.

General Duty Nurses. Gross salary: $163.40 per mo. 8-hr. broken day, 48-hr. wk. All salaries have scheduled rate of increase. Cumulative sick leave. Pension Plan in force. Blue Cross Plan. 3 wks. holiday after 1 yr. service. Apply Supt. of Nurses, Muskoka Hospital for Tuberculosis, Gravenhurst, Ont.

Registered Nurses for new 60-bed General Hospital in prosperous farming community near U.S. border. Salary: $125 per mo. with full maintenance. 6-day wk. Blue Cross paid. $60 per yr. increase up to 3 yrs. 10 days sick leave per yr. 3 wks. holiday per yr. plus 6 days statutory holidays. Apply Supt., Barrie Memorial Hospital, Ormstown, Que.

Registered Nurses for General Duty. 8-hr. day, 48-hr. wk. Total 6 mos. day duty—6 mos. evening & night duty in yr. Gross salary: $145 per mo. days; $150 evenings & nights. Residence accommodation available. Apply Director of Nursing, General Hospital, Belleville, Ont.

General Duty Nurses for 220-bed General Hospital. 8-hr. day, 6-day wk. For further information write Miss M. E. Jackson, Supt. of Nurses, General Hospital, Brandon, Man.

Registered Nurses for following positions with full maintenance in addition to salary: **General Duty Operating Room Nurse**—$130; **Head Nurse for Women's Floor** (34 beds)—$155; **General Duty Nurses**—$130 who alternate during day, afternoon & night shift; **Clinical Supervisor**—$160 per mo. Apply Supt. of Nurses, General Hospital, Medicine Hat, Alta.

Public Health Nurses immediately for Peel County Health Unit, Ont. Salary range: $1,900-2,500 depending on qualifications & experience. Car allowance. Generalized program in rural & semi-urban area. Write Medical Officer of Health, Court House, Brampton, Ont.

Supt. of Nurses for 53-bed hospital—urgent. A most interesting set-up is offered with adequate living accommodation & fair salary. Selected applicant must be able to also act as Principal of School of Nursing which is planned for near future. General administration & business of hospital is carried on by administrator. Apply, stating salary expected, references, etc., Administrator, All Saints' Hospital, Springhill, N.S.

Director of Nurse Education for 320-bed Sanatorium for Tuberculosis. Starting salary: $225 per mo. gross. 44-hr. wk. 3 wks. annual vacation. Pension plan. Group insurance. Blue Cross hospitalization. For further information apply Director of Nurses, Fort William Sanatorium, Fort William, Ont.

Operating Room Supervisor for 120-bed modern hospital with Training School. Must be experienced & have knowledge of latest O.R. technique. P.G. course desirable. Apply, with personal particulars, including qualifications & experience, Supt. of Nurses, Galt Hospital, Lethbridge, Alta.

Infirmières demandées par

LA SOCIÉTÉ CANADIENNE DE LA CROIX-ROUGE

- Service général dans les avant-postes hospitaliers.
- Postes d'infirmières surveillantes et infirmières visiteuses dans les avant-postes infirmiers.
- Service de Transfusion.

Les infirmières, possédant un diplôme reconnu par l'Association des Infirmières du Canada, devront faire parvenir leur demande d'emploi à l'adresse suivante:

Directrice Nationale, Services du Nursing,
La Société Canadienne de la Croix-Rouge,
95 rue Wellesley, Toronto 5, Ontario, Canada

CITY OF TORONTO

DEPARTMENT OF PUBLIC HEALTH

Qualified ***Public Health Nurses*** for a generalized public health nursing service. Salary $2,087 with yearly increases to $2,504 per annum, plus $4.00 weekly Cost of Living Bonus. Five-day week. Sick leave and pension plan benefits.

Apply **Personnel Department, Room 320, City Hall, Toronto.**

Registered Nurses for General Duty in 200-bed hospital in Niagara Peninsula. 48-hr. wk., rotating shifts. Salary: $140 for day duty; $150 for evening duty; $145 for night duty, plus full maintenance & laundry. Increment of $5.00 per mo. at end of 1st, 2nd & 3rd yr. 21 days holiday at end of yr. & 9 statutory holidays. 1½ days sick leave per mo. accumulative to 18 days; staff re-imbursed if not used. Train fare refunded after 12 mos. service. Apply Director of Nursing, County General Hospital, Welland, Ont.

Registered Nurses for General Duty. Gross salary: $158 per mo. 8-hr. duty. Apply Supt., Lord Dufferin Hospital, Orangeville, Ont.

Graduate Nurses for modern 100-bed hospital, 60 miles from Vancouver on Trans-Canada highway. Basic salary: $175 plus present C.O.L. adjustment $5 increase. 4 annual increments: $10, $5, $5, $5. Board, residence, laundry charges, $35 per mo. 44-hr. wk. 10 statutory holidays. 28 days annual vacation. 1½ days sick leave per mo. accumulative to 36 days. Apply Supt. of Nurses, Chilliwack Hospital, Chilliwack, B.C.

Nurses for General Duty (2). Salary: $150 per mo. with full maintenance. 1 mo. holiday with pay after 1 yr. service. Apply Miss M. Flock, Matron, Municipal Hospital, Empress, Alta.

Graduate Nurse—afternoon float, 3:30-11:30, in new 60-bed hospital. Steady work. Also **Floor Duty Nurses,** duties to commence early in Jan. Apply Supt., Alexandra Hospital, Ingersoll, Ont.

General Duty Nurses for 35-bed hospital. 48-hr. wk. Salary: $120 per mo. $5 increase after 6 mos. service. Full maintenance. 3 wks. vacation at end of 1 yr. service. Apply Supt., General Hospital, Kincardine, Ont.

Dietitian (experienced). Write, giving full particulars & when available, to Matron, King Edward VII Memorial Hospital, Bermuda.

Graduate Nurse for General Duty. Small, new, well-equipped General Hospital, attractively situated. Good personnel policies. Some rotation of duties. Opportunities for advancement. Apply Supt., Harrison County Hospital, Corydon, Indiana.

Graduate Nurses for staff positions—**Charge Nurse,** Communicable Disease Ward; **Charge Nurse,** Men's Medical Ward; **Asst. Head Nurse,** Women's Medical Ward; **Asst. Night Supervisor.** Apply, before Feb. 15, to Supt. of Nurses, Royal Alexandra Hospital, Edmonton, Alta.

• WANTED •

SUPERVISOR—WAR MEMORIAL CHILDREN'S HOSPITAL

(Pediatric Department of Victoria Hospital, London)

Position open this Spring or early Summer.

- 140 beds—separate hospital—three floors—good graduate and auxiliary staff—teaching supervisors on two floors.
- Satisfactory salary and personnel policies.
- Applicants must have satisfactory experience in Pediatrics and Administration.

Apply **Director of Nursing, Victoria Hospital, London, Ont.**

• WANTED •

GRADUATE NURSE

as

Director of Red Cross Home Nursing
Windsor, Ont.

Executive Ability and Knowledge
of Public Health Preferred.

Salary: $1,950

Applications received until ***January 22*** at

1266 Ouellette Avenue, Windsor, Ontario

• WANTED •

For joint WHO/UNICEF Projects in the South-East Asia and Western Pacific Regions:

- **Nursing Arts Instructors** with experience in Teaching.
- **Nurses** with experience in Pediatric Nursing and preferably with experience in Teaching.

One- to two-year appointments. ***Basic salary:*** $4,410 per annum.

Apply to:

Personnel Section, World Health Organization, Palais des Nations, Geneva, Switzerland.

Supt. of Nurses for 130-bed hospital with School of Nursing. Age 35-45. Post-graduate course in administration required. Salary open. Suite in modern residence provided. New 175-200 bed hospital in planning stage. Apply, giving details of education, qualifications, experience & enclosing recent photo, to Administrator, Jeffery Hale's Hospital, Quebec City, Que.

Nursing Arts Instructor (1) & Science Instructor (1). New hospital now under construction. For further information apply Supt., Charlotte County Hospital, St. Stephen, N.B.

Operating Room Nurse to be assistant to matron for 35-bed hospital. Salary starts at $195 with increments every 6 mos. 44-hr. wk. 1 mo. holiday with pay after 1 yr. service. Apply Mrs. C. Wilkinson, Matron, General Hospital, Ladysmith, B.C.

Operating Room Scrub Nurse. Salary: $175 per mo. 48-hr. wk. For further details apply Supt. of Nurses, Muskoka Hospital for Tuberculosis, Gravenhurst, Ont.